UNIVERSITY OF CALIFORNIA
MEDICAL CENTER LIBRARY
SAN FRANCISCO

SIGILLVM · VNIVERSITATIS · CALIFORNIENSIS
FIAT LVX
MDCCCLXVIII

EX LIBRIS

Digitized by the Internet Archive
in 2017 with funding from
The National Endowment for the Humanities and the Arcadia Fund

https://archive.org/details/journalofarkansa51unse

U. C. MEDICAL CENTER LIBRARY
JUN 22 1954
San Francisco, 22

JUNE 1954

THE JOURNAL OF THE ARKANSAS MEDICAL SOCIETY

VOL. LI – NO. 1

FORT SMITH, ARKANSAS

FOURTH ARKANSAS RURAL HEALTH CONFERENCE
LITTLE ROCK, JULY 20-21

SLEEP THAT MAKES THE DARKNESS BRIEF

'Seconal Sodium'

(Secobarbital Sodium, Lilly)

rapid action, short duration—patient awakens refreshed

In 1/2, 3/4, and 1 1/2-grain pulvules

ELI LILLY AND COMPANY • INDIANAPOLIS 6, INDIANA, U. S. A.

provides
relief from
a wide variety
of seasonal
allergies

BENADRYL Hydrochloride
(diphenhydramine hydro-
chloride, Parke-Davis)
is available in a variety of forms
—including Kapseals,® 50 mg.
each; Capsules, 25 mg. each;
Elixir, 10 mg. per teaspoonful;
and Steri-Vials,® 10 mg. per cc.
for parenteral therapy.

BENADRYL®

Patients troubled by lacrimation, nasal discharge, and sneezing respond to BENADRYL and enjoy symptom-free days and restful nights.

99635

MEDICAMENTA VERA
PD & CO.
Parke, Davis & Company
DETROIT, MICHIGAN

THE

Journal

OF THE

Arkansas Medical Society

Owned by

THE ARKANSAS MEDICAL SOCIETY

And Published Under Direction of the Council

FOUNT RICHARDSON, M.D., Editor

316 West Dickson Street Fayetteville, Arkansas

MR. PAUL C. SCHAEFER, Business Manager

215 Kelley Bldg. Fort Smith, Arkansas

The Advertising policy of this JOURNAL *is governed by the rules of the Council on Pharmacy and Chemistry of the American Medical Association.*

EXCLUSIVE PUBLICATION—Articles are accepted for publication on the conditions that they are contributed solely to this JOURNAL.

COPYRIGHT, 1954—By The JOURNAL *of the Arkansas Medical Society.*

NEWS—Our readers are requested to send in items of news, also marked copies of newspapers containing matter of interest to the membership.

OFFICERS OF THE ARKANSAS MEDICAL SOCIETY

W. R. BROOKSHER, President ..... Fort Smith
L. H. McDANIEL, President-Elect ..... Tyronza
T. P. FOLTZ, First Vice-President ..... Fort Smith
ELDON FAIRLEY, Second Vice-President ..... Wilson
R. H. WHITEHEAD, SR., Third Vice-President ..... DeWitt
J. J. MONFORT, Secretary ..... Batesville
DANIEL H. AUTRY, Treasurer ..... Little Rock
T. DUEL BROWN, Speaker, House of Delegates ..... Little Rock
C. C. LONG, Vice-Speaker ..... Ozark
MR. PAUL C. SCHAEFER, Executive Secretary
215 Kelley Bldg., Fort Smith

COUNCILORS

First District—JOE VERSER ..... Harrisburg
Second District—HUGH R. EDWARDS ..... Searcy
Third District—J. MAX ROY ..... Forrest City
Fourth District—L. K. HUNDLEY, Chairman ..... Pine Bluff
Fifth District—D. E. WHITE ..... El Dorado
Sixth District—HARRY E. MURRY ..... Texarkana
Seventh District—H. KING WADE, JR ..... Hot Springs
Eighth District—H. ELVIN SHUFFIELD ..... Little Rock
Ninth District—FOUNT RICHARDSON ..... Fayetteville
Tenth District—J. M. KOLB ..... Clarksville

VICE-COUNCILORS

First District—WAYNE WORKMAN ..... Blytheville
Second District—JOHN SNEED ..... Conway
Third District—J. P. WILLIAMS, JR ..... Brinkley
Fourth District—H. W. THOMAS ..... Dermott
Fifth District—GEORGE BURTON ..... El Dorado
Sixth District—CHARLES YARBOROUGH ..... Texarkana
Seventh District—RANDOLPH ELLIS ..... Malvern
Eighth District—ROBERT D. JONES ..... Little Rock
Ninth District—LEE A. DEAN ..... Rogers
Tenth District—LOUIE A. WHITTAKER ..... Fort Smith

Notice on Form 3578-P to be sent to the Arkansas Medical Society, 215 Kelley Building, Fort Smith, Arkansas. Published monthly under direction of the Council, Arkansas Medical Society, at Fort Smith, Arkansas. Vol. LI. No. 1. Subscriptions $3.00 a year. Single copies, 50 cents. Entered as second-class matter, Sept. 23, 1947, at the post office at Fort Smith, Arkansas, under the Act of Congress of March, 1879. Acceptance for mailing at special rate of postage provided for in Section 1103, Act of October 3, 1917, authorized August 1, 1918.

• SPECIAL FEATURES

78th Annual Session, Arkansas Medical Society 1

President's Inaugural Address 4

Proceedings, 78th Annual Session, Arkansas Medical Society 5

30th Annual Session, Woman's Auxiliary to the Arkansas Medical Society 22

Committee on Cancer Control 24

"Anaesthesia in General Practice" 25

The Complications of Cholecystectomy: Prevention and Treatment 29

• FEATURES

"Sparks From the Secretary" 32

Fifty-Year Club Breakfast 32

Obituary 32

Editorial 33

Public Relations 33

Tuberculosis Abstracts 34

Proceedings of Societies 35

Personals and News Items 36

Woman's Auxiliary News 38

W. R. BROOKSHER, M.D.
Fort Smith
President
Arkansas Medical Society
1954-1955

The JOURNAL
OF THE ARKANSAS MEDICAL SOCIETY
PUBLISHED MONTHLY UNDER DIRECTION OF THE COUNCIL

Vol. L June, 1954 No. 1

78th Annual Session
Arkansas Medical Society

PRESIDENT'S ADDRESS*

FIRST GENERAL SESSION

R. C. DICKINSON, Horatio

Before returning to the ranks of obscurity, characterized by past presidents, I ask your indulgence while I present my panaromic views of the practice of medicine.

First, I am proud to say that I am a member of the profession that exemplifies the teachings of the golden rule more nearly than any I know.

Second, I am proud to be an active member of the Arkansas Medical Society, whose basic aim is to promote conditions which allow and encourage us to render service to humanity—and emphasizing that reward or financial gain is a subordinate consideration.

I feel a deep sense of appreciation to all the committee members and others who have worked so hard to make this past year one of achievement and advancement for the medical profession. I especially want to commend:

1. Dr. Ben Saltzman, Chairman of the Rural Health Committee.
2. Dr. H. E. Mobley, Chairman of Industrial Health Committee.
3. Dr. Henry W. Thomas, Chairman of the Medical Education Committee.
4. Dr. Joe Shuffield, Chairman of the Legislative Committee.
5. Dr. Dale Alford, Chairman of the Public Relations Committee.
6. Dr. Louis K. Hundley, Chairman of the Council.
7. Dr. W. R. Brooksher, President-Elect, for his valuable assistance and advice.
8. Dr. Fount Richardson, for work and assistance beyond all expectations.
9. Dr. Hayden Nicholson, Dean of the medical school, for the personal pleasure and satisfaction of having traveled over the State with him and presenting the School of Medicine.
10. Paul Schaefer, for his outstanding work and growing importance to the Arkansas Medical Society.

And above all, to the many friends I have made and endeared over the years in this organization—it is a high privilege to have been associated with you and a signal honor to have been your president. No one could make you the president you deserve—many of us have made you the best we could.

When one is going up a hill, his thoughts are constantly projected to what is on the other side—when he reaches the summit and starts down, his thoughts immediately return to the things he left behind—so I think you might humor me if I reminisce a little—since great store is held by some in such things anyway, history is one of the mainstays in any curriculum of education. It is felt by many to be of great benefit in understanding the present and molding the future.

I started with many of you in the practice of medicine forty years ago. The radius that I influenced and was influenced by was about twenty miles.

To start practicing medicine then required: (1) a bag, (2) some powder, (3) an office and (4) a horse. It cost me about $200.00 I saw 6 to 15 patients per day.

We had four so called specifics, that is—four drugs to treat four diseases: (1) quinine for malaria, (2) mercury for syphilis, (3) diphtheria antitoxin for diphtheria and (4) sulfur for skin diseases.

* Read before the Seventyeighth Annual Session of the Arkansas Medical Society April 19, 1954.

We gave practically every patient calomel—why, I dont' know, but one thing I do know—we convinced ourselves and our patients that we were doing something beneficial for them. Since we had so few diseases we could treat specifically, we turned our attention to the treatment of symptom and to systemic support. Things we today largely ignore because we now have so many diseases we can treat specifically—so we have turned our attentions to the treatment of the disease and away from the treatment of the patient.

Then the doctor treated the patient and he and the family nursed him.

The only charge we made was for professional service—that was all we had to sell.

I could take my bag and powders—treat the patient in his home and give what was agreed by all—the doctor and the general public—as adequate medical care.

These conditions naturally mitigated for a close personal relationship between the doctor and the patient.

Today adequate medical care has grown to mean—to the doctors and the general public—many things: (1) hospitalization, (2) laboratory facilities, (3) insurance and other 3rd parties, (4) research, (5) specialization, (6) drugs, (7) good food, (8) good housing, (9) freedom from worry and many others, (10) fortunately, the basic fundamental of good medical care still remains—namely "professional service" or the personal attention of a physician.

What has been the results of the addition of all these concepts to what constitutes adequate medical care.

Obvious to all the doctors and the general public, there has been a tremendous benefit to the patient in lives saved and suffering relieved.

Also obvious to all—these many changes and additions have lead to many complications, misunderstanding and some dissatisfactions between the doctor and the general public.

The doctors approach to the practice of medicine changed because he knew that his tangible results were much superior; his intangible results were not necessarily so—since there was a degeneration of the close personal relationship between the patient and the doctor. There are too many other people in the act, but the basic fundamentals of the practice of medicine still remain—namely the doctors and the patient—but it is increasingly difficult to separate this from the maze of what constitutes adequate medical care.

The doctor is still just as interested and energetic in helping the patient as formerly.

The patient is still interested in the same thing that he was interested in formerly—namely, himself.

But our relationship with each other is so complicated, by auxiliary factors that we both often lose sight of the fact that we are both interested in the same problem!

Another serious result has been the rearing of the "Midas" head of business and finance into a relationship that has traditionally been one of humanities. This is also a misunderstanding caused by the failure to separate professional service from all the other auxiliaries constituting medical care.

For example: I saw a patient the other day. He had pneumonia—I charged him $3.00. The laboratory and X-Ray charges were $15.00 and I gave him a prescription that cost him $12.00—that is a total of $30.00 but my charge for professional service was only $3.00—about what it would have been 40 years ago!

It seems to me that we have a challenge to meet—how can we maintain and increase these many benefits to our patients and at the same time re-establish ourselves in their love and respect so that when we come home at night after a hard day's work, we don't have to read from our wives' magazines what monsters, charlatans and robbers we are!

Now I ask you to extend your indulgence a little farther while I give you my personal ideas on how to best meet this challenge. It might not be the only answer—it might not even be the right answer.

First, I think we must realize that the number one problem in medicine is the patient. Our number two problem is the disease the patient has, which by a large percentage is psychiatric. It is the one condition that all of us have—100%—in varying degrees.

Next, we should realize that adequate medical care comprises many things and that we are qualified and charged to assume the total burden of supplying one and only one of these many aspects and that is professional care—on this we have a monopoly and should make certain that it is available to all.

Next, we should turn the responsibilities of supplying all the auxiliaries of medical care such as hospitalization, laboratory facilities, drugs, etc., over to the general public—and then assist them to the best of our abilities.

We should remove all third parties from the doctors-patient relationship—by this I mean all insurance companies, labor unions, railroads and the United States Government.

We should welcome and assist anyone who presents an ethical and feasible means to help provide all the other aspects of medical care; be it the community, the church, insurance companies, or the United States Government.

Now when we have solved our problem of furnishing professional care to all the people of the United States, it is our duty to go further and advise the general public as to how they can best obtain all these other aspects of medical care.

True, we have been doing this by advising them to obtain hospital insurance. Here we have done a wonderful service, but it is not enough—it does not care for all the people and will not.

And I am one who agrees that everyone is entitled to good medical care—now what is the best advice we can give the general public on how to make this a reality?

First to me, it seems evident that we are going to have some form of federal health insurance. It is advocated and sponsored by both major political parties.

So, recognizing these facts, we, the doctors, should get together with these agencies and work out some plan that we can be for.

The advocates of socialized medicine claim that their aim is: adequate medical care for all the people. This, of course, is the dream of the medical profession; however, we differ radically with these people on how best to accomplish this end—so far we have failed to find a common way but—

"To every man there openth
A way and a way and a way
The high soul climb the high way
The low soul gropes the low
And in between the mighty flats
The rest drift to and fro."

President R. C. Dickinson, Horatio, administering the oath of office to Incoming President W. R. Brooksher of Fort Smith.

President's Inaugural Address

W. R. BROOKSHER, Fort Smith

An all-wise Creator has graciously granted mankind a few sublime moments that will live with him for the years that are to come. Among these are his marriage, his first-born, the honors that are conferred by his fellows. It has been the lot of your president to experience these. The acceptance of this office is tempered with the knowledge that seventy-eight of our illustrious colleagues have similarly assumed the position with humility and with the hope that they might, in some measure, merit your confidence by leadership and accomplishment.

I know most of you, I know that you are sincere, earnest, God-fearing men who seek to do the most possible for those about you. I know that you will not be swerved from what you feel is right and just by the exigencies of time or place. I know that each of you, each little man with the black bag, seeks to serve humanity without regard for personal sacrifice. I am convinced that your thinking and your actions will lead us to the fulfillment of our highest ideals in medical practice. It shall be my privilege and my pleasure to go along with you.

Arkansas Medical Society Officers for 1954-1955

Back Row, left to right: J. P. Williams, Jr., Brinkley; Elvin Shuffield, Little Rock; John Sneed, Conway; J. M. Kolb, Clarksville; Lee Dean, Rogers; Hugh R. Edwards, Searcy; H. King Wade, Jr., Hot Springs; Eldon Fairley, Wilson; Randolph Ellis, Malvern.

Front Row, left to right: H. W. Thomas, Dermott; J. Max Roy, Forrest City; Joe Verser, Harrisburg; J. J. Monfort, Batesville; L. H. McDaniel, Tyronza; W. R. Brooksher, Fort Smith; Wayne Workman, Blytheville; Louis K. Hundley, Pine Bluff; Fount Richardson, Fayetteville; T. Duel Brown, Little Rock; Daniel H. Autry, Little Rock; C. C. Long, Ozark.

Officers Not Present: Thomas P. Foltz, Fort Smith, First Vice-President; R. H. Whitehead, Sr., DeWitt, Third Vice-President; D. E. White, El Dorado, Councilor, Fifth District; George Burton, El Dorado, Vice-Councilor, Fifth District; Harry Murry, Texarkana, Councilor, Sixth District; Charles Yarborough, Texarkana, Vice-Councilor, Sixth District; Louie A. Whittaker, Fort Smith, Vice-Councilor, Tenth District.

PROCEEDINGS

SEVENTY-EIGHTH ANNUAL SESSION
ARKANSAS MEDICAL SOCIETY
Hotel Goldman, Fort Smith, Arkansas
April 19th, 20th, and 21st, 1954

FIRST GENERAL SESSION

Monday, April 19, 1954
Main Dining Room

A motion picture was shown entitled, "Principles of Fracture Reduction."

The meeting was called to order by President Dickinson.

The invocation was given by the Reverend S. W. Eubanks, Immanuel Baptist Church, Fort Smith.

On behalf of the Sebastian County Medical Society Wright Hawkins welcomed the Arkansas Medical Society to Fort Smith.

President Dickinson addressed the Society and reviewed the progress of medicine during his life time and expressed the hope that medicine would take a constructive part in planning for the health of the American people in the future.

The Scientific Session, presided over by John H. Wilson proceeded as follows:

Daniel J. Moos, Minneapolis, Minnesota—"Intestinal Obstruction"

J. H. Ross, Morelia, Michoacan, Mexico—"General Practice in Rural Mexico"

Malcolm E. Phelps, El Reno, Oklahoma—"Anaesthesia in General Practice"

C. F. Byrns, Editor, Southwest American, Fort Smith—

Monday Afternoon, April 19

PEDIATRIC SECTION

The Pediatric Section held a luncheon meeting at the Goldman Hotel with Pearl Waddell presiding. The program was as follows:

Horace V. Munger, Lincoln, Nebraska—"Advances in Care of Common Pediatric Urological Problems"

Wilbur Lawson, Little Rock—"Factors Predisposing to Hemorrhagic Disease of the Newborn"

Norm Johnson, Little Rock—"Diagnosis of Congenital Heart Disease in Children"

F. E. Shearer, Fort Smith—"Upper Respiratory Infections with Associated Chest and Cardiac Complication"

John Allen Harrel, Little Rock—"Behavior Problems in Daily Practice"

ARKANSAS ACADEMY OF GENERAL PRACTICE PROGRAM

The luncheon of the Arkansas Academy of General Practice was held in the Marine Room of the Goldman Hotel. The guest speakers were J. H. Ross, Director of Sanatorio La Luz, Morelia, Michoacan, Mexico, who is a medical missionary under the Presbyterian Church; and Malcolm E. Phelps of El Reno, Oklahoma, a member of the Board of Directors, American Academy of General Practice.

The Academy held its business meeting and election of officers.

SURGICAL SYMPOSIUM

The Surgery Section held a luncheon and symposium in Parlor A of the Goldman Hotel with John D. Olson, Fort Smith, presiding.

SECOND GENERAL SESSION

3:00 P.M., Main Dining Room

The meeting was called to order by Vice-President J. P. Price and the Scientific Program proceeded as follows:

Robert R. Jackson, Houston, Texas—"The Management of the Acute Seriously Involved Poliomyelitis Patient"

H. V. Munger, Lincoln, Nebraska—"Hematuria"

FIRST SESSION
HOUSE OF DELEGATES

Hotel Goldman, Fort Smith
Monday, April 19, 4:00 P.M.

The meeting was called to order by Speaker Joe Verser.

Secretary J. J. Monfort called the roll of Delegates.

Fount Richardson, Chairman of the Credentials Committee, reported that the credentials of the Delegates present had been examined, found correct and that a quorum was present. The following delegates by counties were present:

ARKANSAS, R. H. Whitehead, Sr.; ASHLEY, M. C. Crandall; BAXTER, B. N. Saltzman; BOONE, Albert Hammon; BRADLEY, W. J. Hunt; CARROLL, D. K. McCurry; CHICOT, H. W. Thomas; CLARK, W. A. Ross; CONWAY, H. E. Mobley; CRAIGHEAD-POINSETT, Rector C. Hooper and J. H. McCurry; CRAWFORD, W. T. Holman, Jr.; CRITTENDEN, Milton D. Deneke; CROSS, Thomas Wilson; DESHA, H. T. Smith; DREW, C. Lewis Hyatt; FAULKNER, Keller Lieblong; FRANKLIN, C. C. Long; GARLAND, Frank Burton, Haynes Jackson; GRANT, Miles Kelly; GREENE-CLAY, A. H. Maddox; INDEPENDENCE, L. T. Evans; JOHNSON, Earle Hunt; LEE, Floyd S. Dozier; LINCOLN, C. W. Dixon; LITTLE RIVER, N. W. Peacock, Jr.; MILLER, C. P. Yarbrough; MISSISSIPPI, Eldon Fairley; NEVADA, O. G. Hirst; OUACHITA, Bruce Brian; PHILLIPS, Wm. Connelly; PULASKI, Hoyt Allen, Joseph Buchman, T. D. Brown, Daniel Autry, Andrew Pringos, R. D. Jones, Gordon P. Oates, Allen Cazort, Joe Norton; SEBASTIAN, Marlin B. Hoge, E. Z. Hornberger, L. A. Whittaker; SCOTT, H. B. Wright; UNION, Jack Sheppard, George Burton; WASHINGTON, Harrison Butler, Ruth Lesh; SECTION ON E.E.N.T., E. C. Moulton, Jr., Fort Smith.

Upon motion (Kolb, Hoge) the House voted to seat the following members as Delegates in the absence of regularly elected Delegates:

JEFFERSON, Charles W. Reid; MONROE, E. D. McKnight; SEVIER, Roger Dickinson.

Dr. Woodson of Poteau, Oklahoma, was introduced to the House as the fraternal delegate from that state.

Upon motion (Monfort, Hoge) the House moved to adopt the minutes of its previous meeting as published in the June, 1953, Journal of the Arkansas Medical Society.

Committees of the Society whose reports had appeared in the March Journal of the Arkansas Medical Society were asked to present any supplements to their report which they might have. Published committee reports were referred to either Reference Committee No. 1 (J. M. Kolb, Chairman; J. W. Headstream; and R. C. Hooper) or to Reference Committee No. 2 (Ross Fowler, Chairman; J. Kenneth Thompson; and Bruce Brian).

Reports not previously printed in the Journal were read as follows:

REPORT OF THE COUNCIL

LOUIS K. HUNDLEY, Chairman

During the year 1953-54 the Council conducted business for the Arkansas Medical Society as follows:

A meeting was held on July 26, 1953, at which the following action was taken:

1. The Council approved an increase in the Executive Secretary's salary. Due to the discontinuance of the editor's honorarium no increase in the budget was necessary.
2. Organized an arbitration commission to be composed of members of the insurance adjustors group and the Industrial Health Committee of the Arkansas Medical Society.
3. Directed the cancellation of Part Two of the contract with the Veteran's Administration covering veteran's care in private hospitals.
4. Commended Dr. Garland Murphy for his excellent work as Liaison between the medical profession and the American Legion.
5. Established an annual rate for members advertising in the Journal of the Arkansas Medical Society at $75.00 for a half page per year.
6. Directed J. M. Kolb, Councilor of the Tenth District, to appoint a new member to fill a vacancy on the State Advisory Committee to Selective Service.
7. Commended the Industrial Health Committee of the Arkansas Medical Society for the good work accomplished by it.
8. Appointed a committee composed of W. R. Brooksher, J. M. Kolb and Fount Richardson to study the report of the American Medical Association's Committee on Relations Between Osteopathy and Medicine.
9. Asked Mr. Warren to investigate the matter of increased liability insurance rates.
10. Commended Dale Alford, Chairman of the Public Relations Committee, for his excellent work and approved the use of doctors' names on radio forums. The Council further moved to ask Pulaski County Medical Society to meet with members of the Arkansas Medical Society's Public Relations Committee to work out rules for selection of participants and operation of the radio forums which would be satisfactory to Pulaski County.
11. Authorized the Executive Secretary to notify the press of any news-worthy action taken by the Council.

The Council met on September 27th and transacted the following business:

1. Asked the Chairman of the Industrial Health Committee to select a Chairman and Secretary of the newly formed arbitration commission.
2. Accepted the resignation of Vice-Councilor Ed Gray of the Eighth District.
3. Accepted and approved the annual audit report of the State Medical Board of the Arkansas Medical Society.
4. Requested President Dickinson to appoint a permanent liaison with the Joint Co-ordinating Committee for Promotion of Health Education in the Schools.

The President also was requested to appoint a member to fill the vacancy left by Dr. Fred Wm. Harris as Liaison to the Arkansas State Practical Nurses Association.

5. Approved the action of the Arkansas State Cancer Commission in discontinuing payments for professional services.
6. Requested Mr. Warren to investigate the circumstances of a case before the Professional Relations Committee of the Seventh District.
7. Voted to oppose the inclusion of private physicians under social security.
8. Directed that all Arkansas Congressmen be advised that the Arkansas Medical Society supports Bill H.R. 10 (Jenkins-Keogh), a bill in Congress which allows physicians to set up tax deferred annuities for themselves.
9. Requested the American Medical Association to furnish all Councilors and Vice Councilors with the **AMA Washington Letter** in order to keep them better informed on current legislative matters.
10. Directed that title to all equipment, apparatus, etc., purchased by volunteer contributions, gifts, bequests, etc., for the benefit of cancer patients of Arkansas should remain in the volunteer organization, Arkansas Division, American Cancer Society.
11. Again voted to request the Pulaski County Medical Society to meet with the State Society's Public Relations Committee to work out details of the operation of a series of radio forums.
12. Questioned Senator J. W. Fulbright on his reason for opposing the Bricker Resolution. Senator Fulbright also discussed Veterans Administration Hospitalization Legislation and pointed out to the Council that organized medicine would have to win over veteran's organizations to medicine's point of view before they could hope to influence the legislators on veterans hospitalization legislation.
13. Voted to defer action to elect R. B. Robins president of the American Medical Association and W. R. Brooksher to a place on the Board of Trustees of the American Medical Association after hearing both members decline to be candidates.

The Council met on January 17, 1954, and conducted the following business.

1. Approved the nomination of, and elected Elvin Shuffield to complete the unexpired term of Ed Gray as Vice-Councilor of the Eighth District.
2. Approved the action of the Executive Committee in delegating Dickinson, Hundley, E. Shuffield, and Mr. Schaefer as representatives of the Society to attend the meeting of the American Medical Association Legislative Committee in Dallas.
3. Resolved that it is within the ethical concepts of the Arkansas Medical Society for any member thereof to appear as a witness in any litigation so long as the member testifies as to matters within his knowledge and to the truth to the best of his knowledge and belief.
4. Granted Cleveland County Medical Society another year until September 1, 1955, to become an active county medical society.
5. Deferred action on dissolution or merging of Prairie County Medical Society.
6. Took cognizance that former Governor, Sid McMath, had failed to select members for the State Board of Health from names submitted to him by the Society for vacancies existing from the First, Fourth and Fifth Congressional Districts. The Council voted to re-submit the names of the nominees for these positions from the First and Fifth District. Due to the death of the nominee from the Fourth District it was directed that members from the Fourth Congressional District be polled by mail for their selection for the position.
7. Directed that any committee expense not previously authorized must be submitted to the Council for its approval before reimbursement is made.
8. Commended the Committee on Medical Education for its study of recommendations for the operation of the University Hospital and Medical Center.
9. Directed that at future Annual Sessions all funds collected for the Annual Session be received and dispensed by the Arkansas Medical Society.
10. Referred to the Committee on Constitutional Amendments a motion that interns and residents be accepted as members without payment of dues.

Upon motion (Murry, Autry) the House approved the actions of the Council.

REPORT OF THE LEGISLATIVE COMMITTEES

JOE SHUFFIELD, Chairman

Your Legislative Committee has had no particular work to do since our last meeting, as the legislature has not been in session. We would like to call this to your attention, and ask you for your wholehearted support during the coming meeting of the legislature in January, February and March of 1955, as it looks like we will have much work to do during that session.

Provision for equipment and operation of the new Medical Center, now rapidly approaching completion, is probably one of the most important matters that will be handled by the next legislature, and your committee has always tried to carry out the wishes of this body towards obtaining favorable legislation for our medical school. This coming legislature will not only be asked to appropriate sufficient money for the medical school, but likely there will be some legislation concerning the admission of patients and charges for services at the Medical Center, and it will be the duty of the State Medical Society to mold the thinking of the members of the legislature to the best advantage for the Medical Center.

Doubtlessly many of you have noticed in the newspapers that the Arkansas Legislative Council is considering writing a bill to set up an Occupational and Professional Licensing Board in Arkansas. If this is done, it will affect the handling of the money by the Arkansas Examining Board to at least some degree. A conference has been held with the committee that has been appointed to write this bill, and the chairman of that committee has definitely promised that they will not write the bill without offering our Society a chance to thoroughly participate in a discussion with reference to that part which will effect our Medical Examining Board. Your committee has collected all the literature that is available on this subject, and is passing it on to the Council, the President of the Arkansas Medical Society, and to the Medical Examining Board, so that they might be properly informed concerning this subject.

There has been some talk concerning a composite examining board for Arkansas, and it is the understanding

of your committee that there is no desire by the State Medical Society for us to participate in such a proposition. It is our understanding that our medical society is very well pleased with our set up so far as examining boards are concerned.

Your committee solicits the advice, help and support of each and every member of the State Medical Society, and we feel that we are going to need your advice and help in the coming year, probably more than we have needed it in any year in the past.

AMENDMENTS TO REPORT OF THE MEDICAL EDUCATION COMMITTEE

H. W. THOMAS, Chairman

The following changes, deletions and additions to the report previously submitted and published in the Journal of the Arkansas Medical Society are listed below:

Page 180, II, (F) "A"—Fee of 25c to 50c to be charged for each outpatient visit (adds word "outpatient" to "A" category).

Page 180, III, (add at end of section)—"This proposal is submitted for your consideration. The committee feels that the primary purpose of the Medical Center is to train men for general practice and the committee strongly emphasized the need for a general practice type of training at the Medical Center and urges that specialty training programs not be expanded at the new Medical Center."

Page 180, IV, (A)—"Proper screening of patients for clinic and hospital by qualified personnel as to financial status."

Page 180, V—Delete "It is recommended that they be allowed to see patients from the metropolitan Little Rock Area only when they are referred by practicing physicians engaged in the same specialty. It is further recommended that they be allowed to see patients in consultation or referral by any practicing physicians from outside the metropolitan Little Rock Area. Further, it is recommended that consultation fees charged be at the upper limits of the fee scale and that the money collected be paid into a non-profit foundation which then pays the various faculty members on a pro rata basis up to a previously agreed upon limit or ceiling, any excess fees being retained by the foundation for research or as subsequently directed.

Page 180, V—Add to end of Section V, the Pulaski County Medical Society at its regular meeting on April 5, 1954, recommended that:

"The Arkansas Medical Society through its Committee on Medical Education, Legislative Committee, and/or other designated groups give their full support in an endeavor to obtain from the legislature an appropriation of funds sufficient to adequately raise the salaries of clinical professors and their associates."

The Committee feels this will take a considerable time to accomplish and in the meantime this committee recommends that faculty members be allowed to see private patients on a referred consultation basis for diagnosis and treatment in order to augment the salaries up to an agreeable maximum figure until such time as salaries may be raised by the legislature.

Page 180, VI—". . . needs no revision at the present time as long as there is no justification for employing all sub-specialists on a full time basis."

Thomas Price addressed the House on the necessity of helping the State Board of Health maintain present services to the people of Arkansas and introduced the following resolution:

"WHEREAS, the American Medical Association has always supported full time state and local public health services; and

"WHEREAS, the Federal Congress has taken the position that public health services are a state and local responsibility and every effort should be made to return this responsibility to states and localities as soon as possible; and

"WHEREAS, Federal grants-in-aid funds for public health services have been reduced over 50% (or $509,000) since fiscal year 1949-50; and

"WHEREAS, additional financial support is necessary for the efficient operation of the state and local health departments; and

"WHEREAS, present unsettled world conditions require the maintenance of a high level of personal and public health; and

"WHEREAS, public health services are accessory to medical services, and the public looks to the medical and allied professions for advice as to what public health services are necessary:

"THEREFORE BE IT RESOLVED, That the Arkansas State Medical Society go on record as supporting full time state and local public health services with adequate state and local appropriations; and

"BE IT FURTHER RESOLVED, That the Society select certain key physicians in each county authorized to speak for the County Medical Society to assist in promoting a public relations program aimed at informing the public and its elected representatives as to the budgetary needs for maintaining adequate state and local public health services."

Upon motion (Hunt, Dickinson) the House adopted the resolution as stated.

Monfort read the proposed constitutional revisions which were adopted as follows:

Section 5. MILITARY MEMBERS. Regular members of the Arkansas Medical Society who are in the service of the Armed Forces of the United States not as career officers may be classified as Military Members, and carried on the rolls of their respective County Societies, as such. Military members shall have a waiver of dues during the time of service, provided that they are in good standing at the time they entered the Armed Forces.

Article V. HOUSE OF DELEGATES. The House of Delegates shall be the legislative body of the Society, and shall consist of: (1) Delegates elected by the component county societies; (2) The Councilors; and (3) ex-officio, the President, First Vice-President, President-Elect, Speaker and Vice Speaker, Secretary and Past-Presidents of the Society provided, however, that the ex-officio members shall have the power of voting on all subjects except the election of officers.

The Council shall consist of the Councilors, the President, First Vice-President, President-Elect, Secretary and Treasurer. The Speaker and Vice-Speaker of the House of Delegates, Past Presidents, and Vice Councilors shall be members ex-officio without vote. Besides its duties mentioned in the By-Laws, the Council shall constitute the

Finance Committee of the House of Delegates. A majority of the voting members shall constitute a quorum, in which consideration a Vice-Councilor acts and votes as a Councilor if the Councilor is not present.

Article X. Funds and Expenses Funds shall be raised by an equal per capita assessment on each component society. The amount of the assessment shall be fixed by the House of Delegates, but shall not exceed the sum of $25.00 per capita per annum, except on four-fifths vote of the Delegates present.

Funds may also be raised by voluntary contributions, from the Society's publications and in any other manner approved by the House of Delegates. Funds may be appropriated by the House of Delegates to defray the expenses of the Society for publications, and for such other purposes as will promote the welfare of the profession. All resolutions appropriating funds must be referred to the Council before action is taken thereon.

The House of Delegates may amend any article of this Constitution by a two-thirds vote of the Delegates present at any Annual Session, provided that such amendment shall have been presented in open meeting at the previous Annual Session, and that it shall have been published twice during the year in a bulletin or Journal of this Society.

Chapter II. Annual and Special Sessions of the Society:

Section 1. The Society shall hold an Annual Session at such place as has been fixed by the House of Delegates at the preceding Annual Session.

Chapter II. Section 3:

In the event the previously selected place is unable to be host to the Annual Session, the meeting place may then be designated by the Council.

Chapter V. Election of Officers:

Section 1 (a). In the event of the death or removal of the President-Elect, the nominating committee at the next Annual Session shall present nominees for President and President-Elect in addition to the other officers.

Chapter VI. Duties of Officers:

Section 3. The Vice-President shall assist the President in the discharge of his duties. In the event of the President's inability to serve, the first vice-president shall serve in his stead.

Chapter VIII. Committees. Section 1:

The standing committees of this Society shall be as follows:

1. Committee on Cancer Control.
2. Committee on Medical Legislation.
3. Committee on Public Health (Liaison with Public Health Department, Rural Health, Maternal Welfare, Tuberculosis, Heart Association, and etc.).
4. Committee on Medical Education (Medical School and Postgraduate work).
5. Committee on Hospitals (Blue Cross, Hospital Liaison and Arkansas Hospital Association).
6. Committee on Public Relations (Speakers, Bureau, Publications and etc., Liaison with Auxiliary, Veterans Administration, Civilian Defense and etc.).
7. Committee on Scientific Work and Exhibits (Scientific Program for Annual Session).
8. Committee on Arrangements for Annual Session (to work with local hosts committee on Annual Session arrangements for hotel, golf, public gathering, and etc.).

Section 1 (a). Additional Committees shall be considered sub-committees of the appropriate standing committee and one member of the standing committee shall be a member of the sub-committee.

Section 1 (b). Unless otherwise provided, these committees shall be appointed by the President for three-year staggered terms. The committee shall consist of not less than six members each, with each president appointing two members for a three-year period. Any vacancies through death, removal or resignation may be filled by the President at the time the vacancy occurs and for the unexpired term of the vacancy. The President and Secretary shall be ex-officio members of all committees.

Chapter VIII. Section 2:

The Cancer Control Committee of the Arkansas Medical Society shall represent the Society in all activities concerned with cancer in the state, shall directly supervise the activities of the Cancer Control Committee of the Woman's Auxiliary to the Arkansas Medical Society and shall cooperate with all agencies within the State of Arkansas dedicated to the problem of cancer.

Chapter VIII. Section 3:

The Committee on Scientific Work shall consist of six members of which the Secretary shall be one. Subject to the instructions of the House of Delegates, this committee shall determine the character and scope of the scientific program for each Annual Session, determining the order in which papers and discussions shall be presented.

Chapter VIII. Section 4:

The Committee on Medical Legislation shall represent the Society in all legislative practice. It shall keep in touch with professional and public opinion and maintain active relations with the Bureau of Legal Medicine and Legislation of the American Medical Association. It shall, at all times, endeavor to shape and guide legislation with a view to securing the best results for the whole people. It shall strive to organize professional influence so as to promote the general good of the community in local, state, and national affairs and elections. During sessions of the General Assembly, it shall keep itself informed as to the bills that are introduced, and shall inform the members of the Society through its Journal or by special bulletins, to the end that legislation inimical to the medical profession and the public shall be defeated, and legislation fostering the interest of the public health and medical practice shall be enacted into law.

Chapter VIII. Section 5:

The Committee on Health and Public Instruction shall represent the Society in those affairs having for their object the improvement in public and personal health, the prevention of epidemics, and the instruction of the people. It shall maintain close relations with the Board of Health, the State Health Officer, and the various health officials, assisting in the adoption of public health programs, the enforcement of sanitary laws, and the promulgation of other health activities of interest to the members of the Society. As occasion demands or when thought advisable, it shall supervise the preparation of articles of timely interest for publication in the newspapers or for broadcasting over the radio for the instruction of the public.

Chapter VIII. Section 6:

The Committee on Medical Education shall serve this State for the Committee on Medical Education of the American Medical Association, and shall have referred to it all questions pertaining to medical education and

postgraduate instruction. It shall maintain close relations with the officials and faculty of the University of Arkansas School of Medicine and Arkansas Academy of General Practice, rendering at all times such assistance as it can in maintaining that institution as a Class A Medical School.

Chapter VIII. Section 7:

The Committee on Hospitals shall have referred to it all questions pertaining to hospitals and their operation; hospitalization of patients, hospital and health insurance, hospital-physician relationships, and shall function as liaison with the Blue Cross-Blue Shield and Arkansas Hospital Association.

Chapter VIII. Section 8:

The Committee on Public Relations shall have referred to it all questions wherein the medical profession as represented by the Society is called upon for advice, for participation in private or public affairs and projects not coming within the duties outlined for the other committees. It shall be the publicity committee of the Society and shall have charge of all publicity issued in the name of the Society. The sub-committee on Professional Relations shall function under this committee.

Chapter VIII. Section 9:

The Committee of Scientific Works and Exhibits shall determine the character and scope of the scientific proceedings of each Annual Session. It shall prepare a scientific program for each Annual Session. It shall solicit and collect material from institutions and individual physicians of the state that is of scientific interest. This it shall arrange and exhibit at each Annual Session. It should particularly strive to obtain material that will more fully illustrate the papers presented in the general meeting of the Society.

Chapter VIII. Section 10:

The Committee on Arrangements for the Annual Session shall provide suitable accommodations for the meeting places of the Society and the House of Delegates, the scientific exhibit, the committees, and shall have general charge of all arrangements. Its chairman shall report an outline of the arrangements to the Secretary for publication in the program and shall make additional announcements during the session as occasion may require.

Chapter IX. Section 6:

Any physician who may feel aggrieved by the action of the Society of his county in refusing him membership, or in censoring, suspending, or expelling him, shall have the right to appeal to the Council, and its decision shall be final, except that a county society shall at all times, be permitted to appeal or refer questions involving membership to the House of Delegates of the Arkansas Medical Society for final determination. That the Council may be aided in rendering just decisions, it is necessary that the By-Laws of each component society provide in detail the routine to be followed in preferring charges and trying any member accused of and tried for any kind of unprofessional conduct.

The following proposed amendment was rejected by the House of Delegates:

Article VIII. Sessions and Meetings.

Section 1. The Society shall hold an Annual Session beginning the third Monday in April of each year, during which there shall be held daily general meetings, which shall be open to all registered members and guest.

Section 2. The place for holding each Annual Session shall be decided by the House of Delegates.

Upon motion (Brooksher, Roy) the following amendment was deferred:

(The House of Delegates did not again consider this amendment at its final session and the amendment was not voted.)

Section 2. New members, and Military Members just returning from service, who are accepted for regular membership after July 1 of each year, are required to pay only one-half of the annual assessment.

Monfort introduced the following new proposed amendments to the By-Laws:

AMENDMENT TO THE BY-LAWS OF ARKANSAS MEDICAL SOCIETY

Chapter I. Addition to Section 4:

An annual affiliate membership may be granted interns and residents who have been recommended as such by the individual County Medical Society in which the internship and residency is located. This type of member shall be accorded full privileges, except that he may not vote, and he shall receive the Journal of the Arkansas Medical Society.

Chapter VIII. Section 1:

(a) Delete "Veterans Administration" from the 6th Committee of Public Relations.

(b) Add after "8. Committees on Arrangements," and before the Section a and b of Section 1, 9, "Committee on Veterans Administration Affairs."

Upon motion (Kolb, Richardson) the House voted to accept them as a first reading.

George Burton presented a resolution having to do with the classifying of medical services as hospital services which was referred to a reference committee for recommendations.

Speaker Verser turned the Chair over to Vice Speaker Brown and then addressed the House opposing the American Medical Association's Cline Committee Report on Osteopathy. Verser received an ovation at the close of his talk, and the House of Delegates, upon a motion (Kolb, Dickinson) voted to instruct Arkansas' delegates to the American Medical Association to attempt to prevent adoption of the Cline Report by the A.M.A. House of Delegates. It was further directed that the Verser Report be sent to all A.M.A. Delegates.

The Speaker announced a vacancy to be filled from the Second Congressional District on the State Board of Health. Schaefer read the list of counties comprising the Second Congressional District and announced that a meeting would be held at 8:30 A.M., April 20th, in Room 116 at the Hotel Goldman at which time members from the district would select three nominees to be presented to the Governor for his appointment.

In meetings on the floor by councilor districts the delegates selected the Nominating Committee as follows:

FIRST DISTRICT: R. C. Hooper; SECOND DISTRICT: L. T. Evans; THIRD DISTRICT: J. M. Roy; FOURTH DISTRICT: H. T. Smith; FIFTH DISTRICT: Bruce Brian; SIXTH DISTRICT: C. P. Yarbrough; SEVENTH DISTRICT: Randolph Ellis; EIGHTH DISTRICT: Hoyt Allen; NINTH DISTRICT: G. H. Butler; TENTH DISTRICT: Earle Hunt (Chairman).

The House adjourned at 5:30 P.M.

Monday Evening, April 19

Hosts for the rotating reception were Cooper Clinic and Holt-Krock Clinic where members and their wives enjoyed music and excellent refreshments. Transportation was furnished by chartered buses which carried passengers from the Goldman Hotel to both parties and back.

THIRD GENERAL SESSION

Tuesday, April 20, 9:00 A.M., Main Dining Room

The meeting was called to order by President Dickinson. A film was shown entitled "Early Detection of Glaucoma," and commented upon by R. C. Cook, Little Rock.

Edwin J. DeCosta, Assistant Professor of Obstetrics and Gynecology, Northwestern University, School of Medicine, Chicago.

Robert A. Ross, Chapel Hill, North Carolina—"Indications for Pelvic Surgery."

E. G. Wakefield, Rochester, Minnesota — "Differential Diagnosis Between Organic and Functional Diseases of the Intestine."

Dave Peel, Chairman, Workmen's Compensation Commission, Little Rock—"The Doctor and the Compensation Law."

MEMORIAL SERVICE

11:30 A.M., April 20, Main Dining Room

President Dickinson presided at the Memorial Service commemorating members who passed away during the year.

The invocation was given by the Reverend Fred G. Roebuck, First Methodist Church, Fort Smith.

Mrs. James Wilson, Fort Smith, sang, "My Faith Looks Up to Thee."

L. H. McDaniel gave the following memorial address:

"IN MEMORIAM"

We come now to pay a tribute of esteem and affection for those members of our Society and our Auxiliary who, since our last meeting, have "gone on the long exodus of death." Words are poor tools with which to fashion the appreciation that our hearts would like to express today. The distance between abstraction and reality is always great, but never greater than when we try to state the meaning of the lives of these great souls who gave themselves fully to our noble profession and now rest from their labors.

When physicians lay down their work it is not like the passing of ordinary citizens. They have held a peculiar relation to the community. They are not simply public agents for the transaction of business. They are public friends. They deal not with the simple external goods of men. They hold the most sacred trusts. Under their hands the strong man lies down upon the scant couch in an unconscious sleep and trusts the thread of life to their careful skill. To them the woman tells her deepest secrets and trusts implicitly to their integrity and honor. They watch over man's entrance and exit from the world. They are family friends. The sick ones wait impatiently for their coming and look with eyes of trust and hope and gratitude into the cheerful, thoughtful face of the physician. People feel that they own their physician. He is subject to their call by day and night. And how many say, after the physician's final departure, with a peculiar consciousness of this close relationship, "He was our doctor." How many testify that from the men of our profession there comes something more than our medicines. It is that elusive something called personality. The patient is better before the medicine is administered.

It is no wonder that in the naming of the early leaders of Christianity, the New Testament writers, while they called Simon "the zealot," and Matthew "the publican," and James and John "the sons of thunder," they called Luke "the beloved physician." When the apostle Paul was physically wretched and lonely, and all his strength was nearly gone, he was writing the last of those letters which now compose such a prominent part of our New Testament. He tells Timothy how all his nearby friends, save one, had left him. You could guess who that one was. Yes, it was Luke, "the beloved physician." He writes: "Only Luke is with me." How happy we are that our Master is so often referred to as "the Great Physician." No, not the great merchant, not the great evangelist, not the great farmer, not the great brickmason, but "the Great Physician."

To physical sight the going from us of these men of medicine may appear to be their extinction, but we must not forget that all man's physical eyes can see is but a fraction of that which is awaiting to be seen.. Modern science tells us there are whole ranges of color which our physical eyes cannot perceive. True, we can see all the colors of the rainbow ranging from red at one end of the spectrum to violet at the other. But now we are assured that this is only a comparatively small fraction of the colors which really exist. Beyond the red rays at one end of the spectrum there are infra-red, beyond the violet are the ultra-violet, and out beyond these there are whole unimaginable reaches of color which we never see at all, because our eyes, as at present constituted, cannot get hold of them. If this be true of our physical eyes, may it not also be true in that realm which we call spiritual?

What was it that gave worth to the lives of these physicians whom we commemorate today? .It was not

nation-wide recognition nor vast political power. The highest human qualities do not need high station to come to fruition. Honesty can be exercised in simple transactions. He that is faithful in little is faithful also in much. Faithfulness is faithfulness whether it characterizes the man in the White House or the physician by the sick bed. To hold these departed physicians in grateful remembrance will be a fresh reminder that some of our best gifts have come to us because they entered the circle of our friendship. The recognition of their passing calls also for new dedication on our part. The end of life on earth calls on us to consider the ends for which life is to be lived. Confronted by death, we must seek for the highest meaning of human friendship.

After a hot summer's day, there often comes with the gathering shadows a silence which seems to say that Nature is waiting for the pageantry of the night. Then, for a moment, there is the breath-taking beauty of the day's afterglow. While we know that the indescribable colors are created by the sun's rays striking back upon the rarefied matter suspended in the upper air, still to many it is a sign that the darkness of the coming night will give way to the splendor of the dawn. So in death, we think of life's afterglow. Every life leaves, after its little day is over, some inspirations of goodness, beauty and truth that remains to comfort and sustain.

What did these lives leave that made them dear to us? What is it that makes our own lives dear to others? Not circumstances, not place and time, not the tie of outward association, not the flesh; these are but the treasure box in which the wealth is contained. It is the real human self that gives the transcedent worth to life. And who shall say that over this real personal self death has obliterating power? Who shall say that death is the extinction of personality? There are those whom you and I would like to see again. It may be that years have passed since they went away, but the passage of time has not dimmed the image of them which we hold in our hearts.

A man was fishing from the bank of the Mississippi when a lad, whom he did not know came to fish beside him. As time passed, they discovered that, although the fishing was poor, the conversation was good. And by the time the sun began to set they had talked of many things. At dusk a large river boat was seen moving slowly in the distance. When the boy saw the boat, he began to shout and to wave his arms that he might attract the attention of those on board. The man watched for some time and then said: "Son, you're foolish if you think that boat is going to stop for you. It's on its way to some unknown place and it won't stop for one small boy." And then the boat began to slow down and move toward the river bank. To the man's amazement it came to the shore and lowered a gang-plank. And as the boy went up the gang-plank, he turned and said to his friendly fellow-fisherman: "You see Mister, I'm not foolish; my father is captain of this boat, and we're going to a new home up the river." Life is like that. The ship of death stops along the river of life to pick up a passenger. But may we not believe that our heavenly Father is captain of the boat and that it is headed for a new home up the river?

I cannot think of a better way to close this inadequate memorial aodress than in the words of Dr. Frank Crane's notable, "Prayer of the Physicians": "We pray, O God, that we may have absolute intellectual honesty. Let others fumble, shuffle and evade, but let us, the physicians, cleave to the clean truth, assume no knowledge we have not and claim no skill we do not possess. Cleanse us from all credulities, all fatuous enthusiasms, all stubbornness, vanities, egotism, prejudices, and whatever else may clog the sound processes of our minds. These are but dirt; make us living personalities as aseptic as our instruments."

"Give us hearts, but let our feelings be such as shall come over us as an investment of power, to make our thoughts clear and cold as stars, and our hands skillful and strong as steel. Deliver us from professionalism, so that we may be alway human, and thus minister to sickly minds as well as to ailing bodies. Give us constant realization of our responsibility, for people believe in us and into our hands they lay their lives. Let us, of all men, be sober and walk in the fear of eternal justice. Let no culpable ignorance of ours, no neglect nor love of ease, spoil the worth of our high calling.

"Make our discretion strong as religion, so that the necessary secrets of souls confided in us may be sacredly kept. Give us the joy of healing. We know how far short we may be of being good men; but dear God, make us good doctors. Give us that love and eagerness and pride in our work without which the practice of our profession will be more fatal to us than to those under our care. Give us a due and decent self-esteem, that we may regard no man's occupation higher than ours, envying not the king upon his throne so long as we are prime ministers to the suffering.

"Deliver us from playing at precedence, from hankering for too much praise and prominence, from over sensitiveness, and all such forms of toxic selfishness. Give us money; not so little that we cannot have the leisure we need to put quality into our service; not so much that we shall grow fat in head and leaden in heart, and forsake our sense of ministry for soft indulgence. Give us courage, but hold us back from over-confidence. Let us so discharge the duties of our office that we shall not be ashamed to look any man or woman in the face. And when at death we lay down our task, may we go to whatever judgment that awaits us, strong in the consciousness that we have done something toward alleviating the incurable tragedy of life. Amen."

President Dickinson read the names of the departed:

IN MEMORIAM

Ernest C. Agee, Marked Tree, December 11, 1953
Charles A. Arkebauer, Van Buren, October 22, 1953
Brian E. Barlow, Dermott, May 21, 1953
A. L. Best, Newport, July 11, 1953
Ludolf N. Bollmeier, Hot Springs, July 6, 1953
E. F. Brewer, Augusta, February 26, 1954
C. M. Brooks, Little Rock, September 2, 1953
Albert S. Buchanan, Prescott, July 4, 1953
H. Gideon Burge, Nettleton, April 28, 1953
Royal Jackson Calcote, Little Rock, June 28, 1953
J. S. Davidson, Forrest City, April 15, 1953
S. N. Doane, Arkadelphia, December 30, 1953
M. D. Duncan, Murfreesboro, September 20, 1953
E. H. Ellsworth, Hot Springs, June 2, 1953
Fred William Harris, Little Rock, August 16, 1953
Carl Mallory Harwell, Osceola, December 26, 1953
Martin C. Hawkins, Parkdale, November 28, 1953
Thomas Luther Hodges, Bismarck, December 3, 1953
Arthur F. Hoge, Fort Smith, February 21, 1954
J. F. John, Eureka Springs, March 24, 1954

Thomas Scott Jordan, Magnolia, September 25, 1953
Leonce J. Kosminsky, Texarkana, May 2, 1953
J. E. Little, Fort Smith, March 16, 1954
George M. Love, Rogers, May 30, 1953
Charles H. Lutterloh, Hot Springs, October 30, 1953
Joseph G. Mitchell, El Dorado, May 3, 1953
David Alex Mohler, Forrest City, October 31, 1953
John M. McCants, Needham, Mass., December 8, 1953
James William Nichols, Helena, July 7, 1953
C. M. Peeler, Pangburn, July 7, 1953
W. B. Reasons, Hermitage, January 20, 1954
John N. Roberts, Little Rock, August 17, 1953
George R. Storm, Helena, April 12, 1954
E. B. Swindler, Stuttgart, June 21, 1953
David Monroe Switzer, North Little Rock, April 25, 1953
Samuel D. Weil, Hot Springs, October 30, 1953

Mrs. James Wilson sang, "Abide With Me," and Reverend Fred G. Roebuck gave the benediction.

EYE, EAR, NOSE AND THROAT PROGRAM

Tuesday, April 20

The E.E.N.T. group met all day beginning at 10:00 A.M. at St. Edwards Hospital. The program proceeded as follows:

G. H. Landers, El Dorado, Chairman, addressed the meeting on, "Problems in Industrial Ophthalmology;

H. A. Bailey, Jr., Little Rock—"Management of Vasomotor Rhinitis";

Ralph Riggs, Shreveport, Louisiana—"Physiological Surgery of the Nasal Septum and Associated Structures";

12:15—Luncheon, with round-table discussion and business meeting until 2:00 P.M. when meeting resumed with O. S. Lee, Hot Springs, speaking on "Plastics Around the Eye," and Wm. J. G. Davis, Washington, D. C., "Some Problems in Muscle Imbalance."

ARKANSAS OBSTETRICAL AND GYNECOLOGICAL SOCIETY

Tuesday, April 20

J. F. Kelsey served as moderator for the luncheon meeting of the Arkansas Obstetrical and Gynecological Society at Sparks Hospital. The program proceeded as follows:

Robert Ross, Chapel Hill, North Carolina — "Intra-Epithelial Carcinoma of Cervix";

Charles Wickard and Melvin McCaskill, Little Rock—"Induction of Labor";

Edwin J. DeCosta, Chicago, Illinois—"Cortisone in Pregnancy"

Eugene Ellison, Texarkana — "Late Puerperal Bleeding."

A business meeting was held at 4:00 P.M.

SECTION ON INTERNAL MEDICINE

Tuesday, April 20

The Section on Internal Medicine had a luncheon in the Marine Room with Louie A. Whittaker of Fort Smith serving as moderator. The guest speaker, W. O. Arnold, Scott-White Clinic, Temple, Texas, spoke on, "Chronic Cystic Lung Disease and Other Ventilatory Problems."

FOURTH GENERAL SESSION

3:10 P.M., April 20, Main Dining Room, Hotel Goldman

The meeting was called to order by J. J. Monfort and the scientific program proceeded as follows:

Jay C. Ketchum, Executive Vice-President Michigan Medical Service, "Blue Shield—The National Scene";

James F. Lewis, Columbus, Mississippi—"Anti-Coagulant Therapy, A Review";

Marlin Hoge, Fort Smith—"Treatment of Perforated Ulcers by Gastric Resection";

Calvin J. Dillaha—"What is the Best Way to Treat Ringworm of the Scalp."

Tuesday Evening, April 20

A Buffet Banquet was held in the Main Dining Room with approximately 400 members, wives and guests attending. President R. C. Dickinson presented President-Elect W. R. Brooksher with a gold wrist watch and announced the establishment of a W. R. Brooksher Scholarship Fund to help needy medical students as a tribute from the individual members of the Arkansas Medical Society for his twenty years of unselfish service as secretary of the Society and as editor of its Journal.

Members of the Sebastian County Woman's Auxiliary entertained after the banquet with a song skit which was so thoroughly enjoyed that they were required to put on a second performance for the overflow crowd which could not be accommodated in the dining room during the first show. Following the entertainment a dance was held in the Marine Room of the Goldman Hotel and was well attended.

W. R. Brooksher receiving gold watch presented by President R. C. Dickinson on behalf of members of the Arkansas Medical Society for twenty years' service as Secretary and Editor. Presentation was made at the Society's annual banquet.

FIFTH GENERAL SESSION

9:00 A.M., Wednesday, April 21

Main Dining Room, Hotel Goldman, Fort Smith

The meeting was presided over by Vice-President John Wilson of Magnolia and opened with a film entitled, "Oral Cancer." The scientific program proceeded as follows:

W. R. Mathews, Shreveport, Louisiana — "The Changing Face of Medicine in a Morgue During the Last Quarter of a Century";

Thomas C. Douglass, Chicago, Illinois — "The Complications of Cholecystectomy; Prevention and Treatment";

James W. Headstream and James T. Wortham, Little Rock—"What Is Being Accomplished by Adrenalectomy";

Harley C. Darnall, Fort Smith—"Treatment of the Unexpanded Pneumothorax";

L. B. Hobson, New York—"Current Problems in Therapy of Infections."

FINAL SESSION

HOUSE OF DELEGATES

Wednesday, April 21, 1954, 1:30 P.M.

Main Dining Room, Hotel Goldman, Fort Smith

The House of Delegates was called to order by Speaker Verser. The following Delegates and members seated as Delegates by action of the House were present:

ARKANSAS, R. H. Whitehead, Sr.; ASHLEY, M. C. Crandall; BAXTER, B. N. Saltzman; BENTON, J. L. Jackson; BOONE, Albert Hammon; BRADLEY, W. J. Hunt; CHICOT, H. W. Thomas; CLARK, W. A. Ross; COLUMBIA, Charles L. Weber; CRAIGHEAD-POINSETT, R. C. Hooper, J. H. McCurry; CRAWFORD, G. K. Patton; CRITTENDEN, Milton D. Deneke; CROSS, Thomas Wilson; DESHA, H. T. Smith; FAULKNER, John Sneed; FRANKLIN, C. C. Long; GARLAND, Frank Burton, G. C. Coffey, Euclid Smith; GRANT, Miles Kelly; GREENE-CLAY, A. H. Maddox; HOT SPRING, Randolph Ellis; HOWARD-PIKE, William Jones; INDE-

PENDENCE, L. T. Evans; JEFFERSON, C. R. Simmons; JOHNSON, Earle Hunt; LITTLE RIVER, N. W. Peacock, Jr.; MISSISSIPPI, Eldon Fairley; MONROE, J. P. Williams; PHILLIPS, Wm. Connelly; PULASKI, Daniel Autry, T. D. Brown, Joseph Norton, Robert Jones, Andrew Pringos, Gordon P. Oates, Joe Shuffield; ST. FRANCIS, Max Roy; SEBASTIAN, Marlin Hoge; E. Z. Hornberger, L. A. Whittaker; SCOTT, E. J. Brown; UNION, D. E. White; WASHINGTON, Harrison Butler, Ruth Lesh; WHITE, Claude Barnett.

Earle Hunt presented the report of the Nominating Committee:

FOR PRESIDENT-ELECT:

L. H. McDaniel, Tyronza.

Earle Hunt, Clarksville.

Fred Krock, Fort Smith.

FOR FIRST VICE-PRESIDENT:

Thomas Foltz, Fort Smith.

FOR SECOND VICE-PRESIDENT:

Eldon Fairley, Wilson.

FOR THIRD VICE-PRESIDENT:

R. H. Whitehead, Sr., DeWitt.

FOR TREASURER:

Daniel Autry, Little Rock.

FOR SECRETARY:

J. J. Monfort, Batesville.

FOR SPEAKER OF THE HOUSE OF DELEGATES:

T. Duel Brown, Little Rock.

FOR VICE-SPEAKER OF THE HOUSE OF DELEGATES:

C. C. Long, Ozark.

FOR COUNCILORS AND VICE-COUNCILORS:

First District: Councilor, Joe Verser, Harrisburg.

Second District: Councilor, Hugh Edwards, Searcy; Vice Councilor, John Sneed, Conway.

Fourth District: Councilor, L. K. Hundley, Pine Bluff; Vice Councilor, H. W. Thomas, Dermott.

Sixth District: Councilor, H. E. Murry, Texarkana; Vice Councilor, Charles Yarbrough, Texarkana.

Eighth District: Councilor, Elvin Shuffield, Little Rock; Vice Councilor, Robert D. Jones, Little Rock.

Tenth District: Councilor, J. M. Kolb, Clarksville; Vice Councilor, Louie Whittaker, Fort Smith.

FOR DELEGATES TO A.M.A.:

W. R. Brooksher, Fort Smith.

R. B. Robins, Camden.

FOR ALTERNATE DELEGATES TO A.M.A.:

Earle Hunt, Clarksville.

R. C. Dickinson, Horatio.

Upon motion of Dixon and Hoge all nominees other than those for President-Elect were elected by acclamation. Earle Hunt and Fred Krock both withdrew their names from consideration in favor of McDaniel who was then elected by acclamation.

Mr. Tom Hendricks, Council of Medical Service of the American Medical Association, was introduced and addressed the House urging unity of thought and action by all Americans.

The report of Reference Committee Number One was read by Chairman J. M. Kolb:

REPORT OF REFERENCE COMMITTEE NUMBER ONE

J. M. KOLB, Clarksville, Chairman
JAMES W. HEADSTREAM, Little Rock,
R. C. HOOPER, Jonesboro

The following reports, which bear no specific recommendations, are accepted and approved as prepared and presented in the Journal of the Arkansas Medical Society for March, 1954, and as supplemented at the meeting of the House of Delegates of the Arkansas Medical Society, April 19, 1954.

1. The Report of the Council.
2. The Report of the State Medical Board.
3. The Committee on Post Graduate Education.
4. The Committee on Veterans Affairs.
5. The Committee on Cancer Control.
6. The Committee on Public Relations.
7. The Committee on Tuberculosis.
8. The Committee on Hospital Relations.
9. The Committees from the 3rd, 7th, 8th, and 10th Councilor Districts Professional Relations Committees.

We wish to commend the Committee on Medical Education with Dr. H. W. Thomas, Dermott, as Chairman, for the outstanding job they have done this past year. They have had monthly meetings which lasted in some instances as long as six hours. They have met with several different groups, including the Liaison Committees of Pulaski County Medical Society and the Legislative Council of the Arkansas General Assembly.

We concur with their recommendations as published in the Journal of the Arkansas Medical Society, March, 1954, Volume 50, No. 10; pages 179 and 180 and as amended by their supplemental report to the House of

Delegates, April 19, 1954, and recommend that their recommendations be approved.

Upon motion of Autry and Shuffield the House adopted the report of Reference Committee Number One.

The report of Reference Committee Number Two was read by Chairman Ross Fowler:

REPORT OF REFERENCE COMMITTEE NUMBER TWO

ROSS FOWLER, Harrison, Chairman
J. KENNETH THOMPSON, Fort Smith
BRUCE BRIAN, Camden

Reference Committee Number Two met during the Annual Session at the Hotel Goldman on April 21, 1954, and considered the various committee reports which have been submitted.

The Committee recommends approval of the resolution concerning recognition of services by pathologist, anesthesiologist and radiologist as physician services rather than hospital services.

The Committee also recommends approval of the following committee reports as presented in the March, 1954, issue of the Journal of the Arkansas Medical Society with the addition of the supplementary resolution by the Arkansas State Board of Health.

Advisor to the Arkansas Practical Nurses Association, Hoyt Choate.

Advisor to Student A.M.A. from the State Society, L. H. McDaniel.

State Board of Health, J. T. Herron.

Liaison to the Joint Co-ordinating Committee for Promoting Health Education in the Schools, H. W. Thomas.

Committee on Child Welfare, William Snodgrass.

Representative to Arkansas State Dental Association, John Greutter.

Committee on Civilian Defense and Disaster Relief, Brooks Teeter.

Committee on Annual Session, Fount Richardson.

Committee on Industrial Health, H. E. Mobley.

Committee on Rural Health, Ben Saltzman.

Report of State Cancer Commission, W. R. Brooksher.

Committee on Medical Legislation, Joe Shuffield.

The reference committee wishes to commend the various committees for the time and effort they have given in making their report possible.

Upon motion of Richardson and Kolb the House voted to accept the report of Reference Committee Number Two.

Louis K. Hundley, Chairman, read a supplementary report of the Council as follows:

The Council met Sunday evening at 8:00 P.M., April 18th at the Hotel Goldman in Fort Smith and transacted the following business:

I. Having studied the budget as published in the March Journal, the Council accepted and approved the proposed budget for the calendar year 1954.

II. Voted to present Mrs. Mason Lawson with an honorarium of $500.00 in appreciation of her activities on behalf of organized medicine both in Arkansas and nationally.

III. Nominated R. C. Dickinson to serve another term as representative of the Arkansas Medical Society on the Board of Arkansas Blue Cross-Blue Shield.

IV. Recommended that each county medical society formulate its own Public Relations program with reference to the care of indigent patients.

V. Approved the application for life membership for the following members:

H. D. Bogart, Marianna
Dr. C. W. Chaffin, Moro
C. W. Donaldson, Green Forest
F. M. Duckworth, Siloam Springs
W. H. Gibbons, Ozark
John S. Hendricks, DeQueen
S. P. Junkin, Little Rock
Frank A. Lee, Vandervoort
D. K. McCurry, Green Forest
C. N. Pate, Hot Springs
H. O. Walker, Newport
J. A. Thompson, Dermott

VI. Approved the application for affiliate membership for the following members:

James R. Barnett, Arkadelphia
Gibbs Biscoe, Dumas
H. L. Brown, Little Rock
R. L. Chrestman, Jr., Helena
A. S. J. Clarke, Fort Smith
H. N. Cogburn, Forrest City
Vance Crain, Wynne
Marvin T. Crow, Warren
Anthony DePalma, Fayetteville
Frank S. Foreman, Bridgeport, Penn.
Jesse K. Grace, Russellville
Oscar Gray, Jr., Little Rock
Frank Gordon, Fayetteville
Joe Bill Hall, Fayetteville
A. J. Harrison, Springdale
J. F. Henry, Little Rock
James C. Hodges, Fort Smith
B. E. Holmes, Fort Bliss, Texas
Ed. G. Hopkins, Jr., Nashville
James P. Jernigan, Little Rock
Miles F. Kelly, Sheridan
Howard Kitchens, Memphis
Ralph Kramer, Fort Smith
Joseph W. Ledbetter, Jonesboro
Dallas D. Miles, Helena
Elsey L. Milner, Little Rock
Louis MacFarland, Hot Springs
Frank Norwood, Mena
J. L. Parker, Snyder
Warren J. Roberts, Camden
Finnis E. Rushing, Augusta
Joseph L. Rosenzweig, Hot Springs
James I. Scarborough, Little Rock
W. F. Shepherd, Jonesboro
George R. Steinkemp, Little Rock
J. S. Stell, Hot Springs
James R. Wayne, Little Rock
J. S. Wilkins, Hot Springs
W. R. Lee, Hot Springs
Warren Murry, Texarkana

VII. Appointed a committee to consider and draft resolutions—committee composed of L. T. Evans, S. J. Allbright and Mr. Peter A. Deisch.

VIII. Moved to re-iterate the Society's approval and support of the Essay Contest carried on by the American Association of Physicians and Surgeons and referred the matter to the House of Delegates for their approval.

IX. Considered proposed legislation for centralization of all licensure boards and ordered the problem referred to the Committee on Legislation.

X. Heard a report by Secretary Monfort on the excellent accomplishments of the newly established Arbitration Commission.

XI. Authorized the holding of a senior class medical day and set aside a sum not to exceed $500.00 for this purpose.

The Council met Monday, April 19th, at 12:15 at the First Christian Church in Fort Smith.

Mr. Winthrop Rockefeller spoke at length regarding his plans for developing a clinic to be used as a pilot study for the development of community health centers in isolated areas.

After further explanation and discussion by Dean Nicholson of the School of Medicine, the Council approved the proposed plan and referred it to the House of Delegates for its action.

The Council met Tuesday at 12:15, April 20th, at the First Christian Church in Fort Smith and transacted the following business:

I. Accepted and approved the report of the Committee to cooperate with the Manion Commission having to do with the interrelationship of boards and governmental agencies operated on funds received from federal and state money.

II. Appointed a committee to study a request by the Section on Orthopedics to recommend to the American Medical Association that the specialty on Physical Medicine and Rehabilitation cease to use the word "rehabilitation" in their title.

III. Directed that, due to continued inactivity, the Prairie County Medical Society be dissolved and that its members be invited to join adjacent county medical societies.

IV. Directed that a telegram of good wishes be sent to Dr. J. D. Riley, incapacitated and unable to attend this meeting.

V. Recommended that Dr. J. A. Thompson be accepted as a life member of the Arkansas Medical Society upon payment of three years' back dues.

The Council met Wednesday at 12:15, April 21st, at the First Christian Church, Fort Smith, and transacted the following business:

I. Approved a resolution of appreciation to the host society, Goldman and Ward Hotels, newspapers, radio and television, First Christian Church, Sebastian County Auxiliary and others who have contributed so much to making the 78th Annual Session such an outstanding success.

II. Approved life membership for Dr. S. P. Junkin of Sweet Home, Arkansas.

III. Approved affiliate membership for Dr. Ruth Junkin.

IV. Accepted and approved report of Special Committee on Veterans' Administration and directed that it be published in the Journal of the Arkansas Medical Society.

V. Accepted and approved audit report.

VI. Tabled motion to drop word "rehabilitation" from title of Specialty on Physical Medicine and Rehabilitation.

VII. Directed message be sent Mrs. Charles Chamberlain expressing hope for speedy recovery.

Chairman Hundley then made a special report to the House of Delegates as follows:

At the Monday noon meeting, April 21st, of the Council, Mr. Winthrop Rockefeller met with the Council and requested the Society's approval and cooperation in the planning and execution of a research project into the provision of medical care in rural areas. This project is to be carried out under the direction of the University of Arkansas School of Medicine. In the beginning, a pilot plan will be put into operation in an area which is currently without medical services. A minimum medical unit will be established with local community participation. Services will be furnished to the community on a level for which they can pay. Evaluation of all aspects of the founding and operation of the pilot study will be carried out by a research unit. As an integral part of the control of this plan Mr. Rockefeller requests a Medical Advisory Committee be furnished from membership of the Society and the Arkansas Academy of General Practice. The Council has voted to support the plan as presented.

On the motion of Brooksher and Kolb the House voted unanimously to approve Mr. Rockefeller's project and to give it the Society's full support.

Joe Verser informed the House of a bill which had been proposed to the Legislative Council of the Arkansas Assembly, which would centralize all licensing boards placing them under the authority of a lay secretary. Joe Shuffield then spoke at length on the subject and advised the House that in his opinion it did not have a chance to become law and the Society should take no action with regard to it at this time. Upon motion of Richardson and Dixon the House voted to take no position in regard to the bill.

Mr. Schaefer read the following names of nominees to the State Board of Health selected by the Second Congressional District: E. D. McKnight, Brinkley; L. T. Evans, Batesville; S. J. Albright, Searcy.

Upon motion of Workman and Edwards the House approved the list of nominees.

On behalf of the Committee on Revision of the Constitution J. M. Kolb presented a substitute amendment for Article 8, Section I as follows:

Article VIII. Sessions and Meetings:

Section 1. The Society shall hold an Annual Session beginning the third Monday in April of each year, during which there shall be held daily general meetings, which shall be open to all registered members and guests.

Section 2. The place for holding each Annual Session shall be decided by the House of Delegates.

Section 3. Should the third Monday in April not be feasible to the Host Society, then the time of meeting may be changed to a later date by the Council.

After much discussion and parliamentary maneuvering the House voted against acceptance of the substitute amendment.

Gordon P. Oates presented the following resolution which was approved by unanimous vote:

"WHEREAS, the National Foundation for Infantile Paralysis has for many years supported scientific research in both the care and prevention of poliomyelitis; and

"WHEREAS, Dr. Jonas E. Salk, working on a grant from the National Foundation for Infantile Paralysis to the University of Pittsburg, has developed a killed-virus vaccine which has been demonstrated to have the ability to stimulate the body to produce ant-bodies against poliomyelitis; and

"WHEREAS, there has been formed a special vaccine advisory committee to devise tests to insure the safety of the vaccine; and

"WHEREAS, the vaccine's safety is tested by (1) the manufacturer (2) Dr. Salk's laboratory and (3) the laboratory of Biologics Control of the National Institute of Health;

"THEREFORE BE IT RESOLVED, that the Arkansas Medical Society go on record as supporting and approving the forthcoming poliomyelitis vaccine field trials."

Marlin Hoge spoke briefly on the desirability of establishing a sub-committee on mental health. Upon motion of Hoge and Kolb the House directed that a sub-committee on Mental Health be appointed as a part of one of the regular standing committees.

Louis K. Hundley moved and the House approved the following resolution of appreciation:

RESOLVED that the Arkansas Medical Society desires to express its grateful appreciation and heartfelt thanks to the Sebastian County Medical Society, the Sebastian County Medical Auxiliary, the Arkansas Academy of General Practice, St. Edwards Hospital, Sparks Hospital, the ladies of the First Christian Church, K.F.P.W., radio station, K.F.S.A., radio station, K.W.H.N., radio station, K.F.S.A.-TV television station, the Goldman Hotel, the Ward Hotel, the Southwest American, the Times Record, and the city of Fort Smith, for the cordial welcome, the extension of unbounded hospitality, the expressions of good will and kindly feelings shown each member of this Society who have been privileged to attend our sessions. We feel stimulated and enlightened by what we have seen and heard.

We like to hope that these virtues of yours are the virtues of the profession, and that the qualities which have made you excel as truly inspiring and delightful hosts and hostesses, warmth of heart, unselfishness, thoughtfulness, forthrightness, are the qualities of a good doctor.

Now that we are homeward bound we realize that you have truly put into effect the old words of welcome:
"Come in the evening, or come in the morning,
Come when you are looked for, or come without warning,
Whenever you come, there is no one before you,
The more often you come, the more we'll adore you!"

The House adjourned sine die at 3:30 P.M.

FINAL GENERAL SESSION

April 21, 1954, 3:30 P.M.

Main Dining Room

President Dickinson called the meeting to order and presented the Past Presidents seated on the rostrum.

President Dickinson addressed the Society expressing his appreciation for the help of all members and especially the committees who had carried out his program.

At the request of President Dickinson, Joe Shuffield, Earle Hunt, and H. T. Smith escorted W. R. Brooksher, President-Elect, to the platform where he took the oath of office administered by Dickinson.

President Brooksher voiced his appreciation for the honor bestowed on him by the Society both in selecting him as its President and in electing him to the permanent position of Secretary Emeritus and in the establishment of the scholarship in his name.

At the request of President Brooksher, Joe Shuffield and T. Duel Brown escorted President-Elect L. H. McDaniel to the rostrum where he was introduced to the Society in his new capacity. He expressed his appreciation for the honor given him and his hopes for the continued improvement of the medical profession.

On behalf of the Pulaski County Medical Society, Elvin Shuffield invited the Society to meet in Little Rock in 1955. H. King Wade, Jr., extended an invitation on behalf of the Garland County Medical Society for the Society to hold its 1955 meeting in Hot Springs, pointing out that it would be necessary to have the meeting late in May if the House should decide to hold it there. By a standing vote the meeting accepted the invitation of the Garland County Medical Society.

The Society adjourned its 78th Annual Session at 4:00 P.M.

COUNCIL MEETING

The new Council met briefly for organization and elected Louis K. Hundley chairman. Fount Richardson was elected Editor of the Journal.

ATTENDANCE

Physicians	383
Exhibitors	51
Visitors	15
Grand Total	449

OFFICERS OF THE ARKANSAS MEDICAL SOCIETY—1954-55

President.....W. R. Brooksher, Fort Smith
President-Elect.....L. H. McDaniel, Tyronza
First Vice-President.....T. P. Foltz, Fort Smith
Second Vice-President.....Eldon Fairley, Wilson
Third Vice-President.....R. H. Whitehead, Sr., DeWitt
Secretary.....J. J. Monfort, Batesville
Treasurer.....Daniel H. Autry, Little Rock
Delegates to A.M.A.—
W. R. Brooksher, Fort Smith; R. B. Robins, Camden
Alternate Delegates—
R. C. Dickinson, Horatio; Earle Hunt, Clarksville
Speaker, House of Delegates....T. Duel Brown, Little Rock
Vice-Speaker.....C. C. Long, Ozark
Journal Editor.....Fount Richardson, Fayetteville

EXECUTIVE COMMITTEE OF THE COUNCIL

Chairman.....Louis K. Hundley, Pine Bluff
President.....W. R. Brooksher, Fort Smith
President-Elect.....L. H. McDaniel, Tyronza
Secretary.....J. J. Monfort, Batesville

MEDICAL COUNCILOR DISTRICTS

First District

Councilor.....Joe Verser, Harrisburg
Vice Councilor.....Wayne Workman, Blytheville
Clay, Craighead, Crittenden, Fulton, Greene, Lawrence, Mississippi, Poinsett, Randolph and Sharp.

Second District

Councilor.....Hugh R. Edwards, Searcy
Vice Councilor.....John Sneed, Conway
Cleburne, Conway, Faulkner, Independence, Izard, Jackson, Stone and White.

Third District

Councilor.....J. Max Roy, Forrest City
Vice Councilor.....J. P. Williams, Jr., Brinkley
Arkansas, Cross, Lee, Lonoke, Monroe, Phillips, Prairie, St. Francis and Woodruff.

Fourth District

Councilor.....Louis K. Hundley, Pine Bluff
Vice Councilor.....H. W. Thomas, Dermott
Ashley, Chicot, Desha, Drew, Jefferson and Lincoln.

Fifth District

Councilor.....D. E. White, El Dorado
Vice Councilor.....George Burton, El Dorado
Bradley, Calhoun, Cleveland, Columbia, Dallas, Ouachita and Union.

Sixth District

Councilor.....Harry E. Murry, Texarkana
Vice Councilor.....Charles Yarborough, Texarkana
Hempstead, Howard, Lafayette, Little River, Miller, Nevada, Pike, Polk and Sevier.

Seventh District

Councilor.....H. King Wade, Jr., Hot Springs
Vice Councilor.....Randolph Ellis, Malvern
Clark, Garland, Grant, Hot Springs, Montgomery and Saline.

Eighth District

Councilor.....H. Elvin Shuffield, Little Rock
Vice Councilor.....Robert D. Jones, Little Rock
Pulaski.

Ninth District

Councilor.....Fount Richardson, Fayetteville
Vice Councilor.....Lee A. Dean, Rogers
Baxter, Benton, Boone, Carroll, Madison, Marion, Newton, Searcy, Van Buren and Washington.

Tenth District

Councilor.....James M. Kolb, Clarksville
Vice Councilor.....Louie A. Whittaker, Fort Smith
Crawford, Franklin, Johnson, Logan, Perry, Pope, Scott, Sebastian and Yell.

REPORT OF SPECIAL COMMITTEE ON VETERANS ADMINISTRATION

H. ELVIN SHUFFIELD, Chairman

This Committee brings you greetings from the American Medical Association, the Council on Medical Service, and the Committee on Federal Medical Services, and we would like to assure you that these men are working diligently on our problems. During the past three years, many resolutions concerning Veterans care, have been introduced in the American Medical Association House of Delegates. All of these activities have been directed toward establishing basic policy concerning the medical and hospital care of Veterans. From the actions taken by the House of Delegates in December, 1952, and June, 1953, it is evident that the medical profession has crystalized its views and has established a clear and firm policy.

In its deliberations the House of Delegates recognized that the portion of policy referring to non-service connected cases would be extremely controversial. With this in mind it recommended most earnestly:

"Your House of Delegates recommends with respect to the provision of medical care and hospitalization benefits for veterans in Veterans Administration and other federal hospitals that new legislation be enacted limiting such care to the following two categories:

(a) Veterans with peacetime or wartime service whose disabilities or diseases are service-incurred or aggravated; and

(b) Within the limits of existing facilities to veterans with wartime service suffering from tuberculosis or psychiatric or neurological disorders or non-service-connected origin, who are unable to defray the expenses of necessary hospitalization.

"Your House of Delegates recommends that the provision of medical care and hospitalization in Veterans Ad-

ministration hospitals for the remaining groups of veterans with non-service-connected disabilities be discontinued and that the responsibility for the care of such veterans revert to the individual and the community, where it rightfully belongs.

"The recommendation of the House of Delegates with respect to the treatment of veterans with tuberculosis and neuropsychiatric disorders of non-service origin in federal hospitals is believed necessary at this time because of the inadequacy of local facilities designed to provide treatment for all such cases. It is the feeling of the House of Delegates, however, that the entire question of whether the care of these patients is a local or a federal responsibility must be reanalyzed by the Congress. The rapidly expanding veteran population and the need for facilities for the remainder of our citizens afflicted with these diseases suggests that community facilities must be developed under state or local administration for the benefit of all. Preferential treatment for veterans with these non-service-connected disabilities cannot be continued indefinitely, in view of its detrimental effect on the health and the economy of the entire nation.

"In conclusion, your House of Delegates would like to stress the fact that these recommendations do not suggest any limitation or impairment of the hospitalization of medical care now available to veterans who have become physically handicapped as a result of military service. We are in complete accord with that program.

"Your House of Delegates also recommends most earnestly that all of the facilities of the American Medical Association and of its constitutent state and county societies be employed immediately to disseminate background information and accurate statistical data in this regard. Every effort should be made to inform the profession and the public concerning the nature of the problem, the position of the American Medical Association and the reasons on which that position is predicated."

It is agreed that the federal government should provide every reasonable benefit to veterans who were disabled as a result of military service. However, the federal government also grants free life time medical and hospital benefits to each war veteran who claims he cannot afford private care, even though he suffered no mishap while in uniform.

The United States veteran population is increasing at the rate of 1,000,000 each year; consequently the Veterans Administration medical care program is now second in size and expense only to Great Britain's nationwide system of government medicine.

Briefly, in the way of legislative history, in 1811 Congress established a U. S. Naval Home in Philadelphia, which although more of an old service man's home, operates as a general hospital. More than 100 years passed before the Congress, in 1917 authorized the first purely medical benefits for Veterans, and medical care was restricted exclusively to veterans with service-connected disabilities. Then in 1923 Congress authorized for the first time, medical treatment for veterans with "service-connected" disabilities. At that time, due to a reduction in the "service-connected" patient load, there were some beds available, and Congress through the Act of March 4th, 1923, authorized the care of Veterans of the Spanish American War, Philippine Insurrection, and the Boxer Rebellion, suffering from neuropsychiatric or tuberculous diseases, whether or not service connected. This entitlement none the less, necessitated the construction of additional hospital facilities.

Then came the Act of July 2nd, 1926. This legislation provided liberalized hospitalized hospitalization privileges whenever existing facilities were available to veterans of any war, military occupation, or expeditions, not dishonorably discharged, without regard to the nature or origin of their disabilities. This law qualified approximately 5,000,000 men and women veterans for free medical care for life at public expense, resulting in a huge influx of veterans at the government institutions. This law was repealed seven years later by the Economy Act of 1933.

What are the requirements now for V. A. medical care? Medical care and hospitalization are granted to:

1. Veterans with disabilities attributable to service in the armed forces, and to
2. War veterans with non-service-connected disabilities, within limits of the existing facilities, if they are unable to pay for private medical care.

These are the provisions of Public Law 2 of 1933, and Public Law 141 of 1934, as amended, the basic legislative authority for veterans medical care.

As you see, with the one exception of the Economy Act of 1933, each successive law has further expanded the V. A. Medical Care program. Public Law 791, 81st Congress, enacted in 1950 (incidentally over the President's veto) is significant in its trend. It entitles all Spanish American War veterans to free out-patient care, regardless of the nature or origin of their disability. From statistics it has already been proven that older veterans are hospitalized more frequently for civilian incurred ailments than for service-connected disabilities. As the years pass, from the time of military discharge, the need for treatment of civilian incurred illnesses increase, while fewer patients require care for service-connected disabilities.

In January, 1952, 46.3% of World War II patients in V. A. Hospitals had service-connected disabilities compared to 19.7% of World War I patients, and 3.4% of the patients from earlier wars. The veteran population is increasing at a rate of almost 1,000,000 persons per year, and as you can see these will need more frequent and prolonged medical care as the years pass. With this brief information, one can readily see the endless result of such a tremendous program. Is it a proper charge on the remainder of the population? Will it bring the best medical care to the veteran, and will it undermine the civilian hospital program of the nation? Definitely not. U. S. physicians are in complete accord with the overwhelming sentiment of the American people that the federal government has a duty to care for any man who has become physically or mentally handicapped as the result of military service. However, they question the wisdom of providing free medical care to those veterans (at the expense of the rest of the population) who suffered no injury or illness while in uniform.

This Committee would like to bring a few facts to your attention:

1. The Veterans Administration maintains three times the number of beds needed for treatment of service connected cases.
2. The total number of veterans waiting for Veterans Administration hospitalization was 22,613 as of June 30th, 1953.
3. Of these 22,613 veterans who are awaiting admittance, only three had service-connected disabilities.

4. For general medical and surgical patients, only an average of almost 9 veterans were admitted for each bed in 1951, while in private hospitals during a year's time each bed is utilized to provide care for 35.4 patients.
5. In 1951 Veterans Administration hospitals discharged 511,895 patients, of whom 442,789 had been treated for general, medical and surgical disabilities. In other words, only 15.4% of these patients had been treated for service-incurred illness or injury. The remaining 84.6% were hospitalized for disabilities received in civilian life.
6. In a survey of 500 veterans, picked at random, being treated for non-service-connected ailments in V. A. hospitals, 336 had annual incomes of $4,000.00 to $50,000.00, with 25 of these having real estate or other assets between $20,000.00 and $500,000.00. Another patient was found to be earning a salary of $10,000.00 annually while drawing $195.00 monthly compensation from the federal government for almost total disability.
7. The average V. A. hospital stay for a patient receiving general, medical and surgical care is 30 days, as compared to 7.5 days for patients of similar disabilities in a civilian hospital.

The federal government duplicates facilities by providing funds for hospital construction for two classes of citizens: For civilians, it has the Hill-Burton Act, and for veterans, the Veterans Administration. If the majority of the veterans without service-connected disabilities were treated in civilian hospitals on the same basis as the rest of the population, the Veterans Administration medical personnel requirements would be considerably reduced. The end results of this duplication is that the government hospitals compete with the civilian hospitals, both for personnel and patients. Although the federal government, aided by state and local sub-division, is spending millions of dollars under the Hill-Burton Act in civilian hospital construction, it is becoming increasingly difficult for these hospitals to operate at a reasonable cost, because the patient and health personnel are being diverted into hospitals wholly supported by the federal government. This conflict is causing a continual increase in the cost of hospital and medical care for persons who must pay their own way. And incidentally, gentlemen, it cost $4,000.00 more to build a bed for the Veterans Administration than it does for the Hill-Burton Act.

Now, the subject that is very important to all of us, in addition to one's well being, is the cost of medical care. The cost of benefits to Civil War veterans was twice the cost of financing the entire war. For the Spanish American war the cost of veteran benefits is already six times that of the war. The cost of World War I benefits has already exceeded the cost of that war. If the present veterans benefits are continued, close to a trillion dollars will be spent on World War II veterans. The direct cost of World War II is estimated at three hundred and fifty one billion dollars. Since the end of the war, veterans benefits already have approximated 10 per cent of this amount. The total cost for one year is $692,499,200.00. The Veterans Administration medical program is second in size in expense only to the nation-wide system of socialized medicine of Great Britain.

This committee would like to make the following recommendations:

1. That the Arkansas Medical Society appoint a permanent committee to continue this program on the Veterans Administration, and recommend that each county Medical Society have a similar committee.
2. That each doctor try his best to bring this information on the Veterans Administration before civic groups.
3. For all of us to try to prove to our Congressmen that all veterans cannot feel alike about the Veterans Administration, and that the Veterans Service Organizations are not as powerful as these organizations try to represent themselves to be.
4. We would like to urge all doctors who are veterans to join service organizations, and particularly the American Legion, to become active members working in a constructive manner to help Veterans Organizations formulate programs good for the veterans and the country. We wish to point out that the work of the American Legion Rehabilitation Committee should be of great interest to all physicians.
5. Whenever a doctor signs the V. A. form 10-P-10, please instruct the patient that this is a report of the physical examination and is not the recommendation of hospitalization or admission to a Veterans Administration Hospital.

The programs, speeches and actions to carry out the policy of the House of Delegates should be planned on the basis of principle, rather than a personal attack on other organizations. It will probably take us several years on this program, because to win through on this principle, public opinion must be aroused. It is a long-term program, and can only be resolved by developing an informed public.

MRS. HOYT CHOATE
Little Rock
President, Woman's Auxiliary to the Arkansas Medical Society, 1954-1955

Thirtieth Annual Session

WOMAN'S AUXILIARY TO THE ARKANSAS MEDICAL SOCIETY

The Woman's Auxiliary to the Arkansas Medical Society met for its Thirtieth Annual Session on April 20th and 21st in the Ward Hotel, Fort Smith, Arkansas. One hundred and fifty-seven members registered during the two days.

Mrs. A. A. Little presided over the Pre-Convention Board meeting Monday morning. At this meeting the Board recommended to all County Auxiliaries that their donations for the American Medical Education Foundation be sent to the State Treasurer or the Funds Chairman rather than directly to the Foundation, then at the end of the year a check for the total amount will be sent in. The following members were elected to serve as Nominating Committee for next year: Mrs. A. A. Little, Texarkana, Chairman; Mrs. T. Duel Brown, Little Rock; Mrs. Robert Thompson, Fort Smith; Mrs. Warren Riley, El Dorado, and Mrs. J. J. Monfort, Batesville.

Mrs. A. S. Koenig, President of the Sebastian County Auxiliary, called the First General Session to order at ten o'clock, and following the Invocation, Mrs. John D. Olsen, Forth Smith, gave the address of welcome, with Mrs. J. P. Price of Monticello responding for the visiting members. Mrs. A. A. Little was introduced and took charge of the business meeting. Honored guests presented were Mrs. George Feldner, New Orleans, Louisiana, President of the Woman's Auxiliary to the Southern Medical Association, and Mrs. Mason Lawson, Little Rock, Treasurer of the Woman's Auxiliary to the American Medical Association. Reports were heard from the Councilor to the Southern Medical Association Auxiliary, the State Officers, District Council Women and Committee Chairmen. The body voted the adoption of the proposed Constitution and By-Laws as revised but also added to the list of

standing committee chairmen a Chairman of Funds. They also voted to send $50.00 to the American Medical Education Foundation and allocate it to the University of Arkansas Medical School.

At the luncheon on Monday, in the Gold Room of the Ward Hotel, the guest speaker was Mrs. George Feldner who brought greetings from the Auxiliary to the Southern Medical Association. In the afternoon, the wives of staff members of the Camp Chaffee Hospital gave a tea for the Auxiliary. They arranged a display of articles from some foreign countries in which their army personnel have lived, and also presented a musical program given by members of the Special Services Group stationed at the camp.

Dr. R. C. Dickinson, President of the Arkansas Medical Society, spoke to the Auxiliary at the Second General Session Tuesday morning, April 20th. Reports of the County Presidents were heard. The following officers for the coming year were elected, and installed by Mrs. Mason Lawson: President, Mrs. Hoyt Choate, Little Rock; President-Elect, Mrs. John T. Gray, Jonesboro; First Vice-President, Mrs. Jack Kennedy, Arkadelphia; Second Vice-President, Mrs. Clyde Hart, Pine Bluff; Third Vice-President, Mrs. Joe Verser, Harrisburg; Fourth Vice-President, Mrs. Lawrence Siegle, Fayetteville; Recording Secretary, Mrs. T. Duel Brown, Little Rock; Corresponding Secretary, Mrs. J. R. Warden, Little Rock; Treasurer, Mrs. V. T. Webb, Little Rock; Publicity Secretary, Mrs. Gordon P. Oates, Little Rock; Historian, Mrs. C. W. Garrison, Little Rock, and Parliamentarian, Mrs. C. E. Kitchens, DeQueen.

Mrs. Koenig presided at the luncheon in the Hardscrabble Country Club, and the speaker of the day was Mrs. Mason Lawson, Treasurer of the Woman's Auxiliary to the American Medical Association. The high point was reached, however, in the outpouring of love and respect when representatives from the Arkansas Medical Society, the Pulaski County Medical Society and the Auxiliary to the Pulaski County Medical Society joined the State Auxiliary in paying tribute and presenting gifts to Mrs. Lawson in recognition of her exceptionally fine work in the County, State and National Medical Auxiliaries.

Mrs. Hoyt Choate, newly installed President, conducted a Workshop Wednesday morning, handing out Workbooks to the new Board members and having a round table discussion of problems and plans regarding the coming year's work. Dr. Edwin Gray, President-Elect of the Pulaski County Medical Society and member of the Advisory Board, was presented to the group, as were Dr. Ben Saltzman, Chairman of the Rural Health Committee for the Arkansas Medical Society, and Dr. Dale Alford, Chairman of Public Relations.

Mrs. T. Duel Brown,
Recording Secretary.

Committee on Cancer Control

C. A. ARCHER, M.D., Chairman

TIME AND THE TREATMENT OF CANCER

The importance of early treatment in the cure of cancer is perhaps stressed unduly by the profession and by the public. Admittedly, effective treatment should be carried out before the initial lesion metastasizes to other areas of the body. It is conceivable that all cancers might be cured were they detected at a sufficiently early stage of growth.

This emphasis on the importance of early treatment should not detract from the proven fact that many "late" cases may be successfully managed.

The variations in the growth of malignancies are tremendous. Metastasis may occur while the original lesion is of microscopic size; others may remain well-localized for months or even years.

Early treatment is important and desirable but treatment with due regard to the complex nature of the growth of malignant cells, to their manifold variations in different sites, and regardless of whether the case may be termed "early or late," is the more important. The profession's responsibility is not to deny treatment but to endeavor to extend the application of proven methods to more and more patients.

"ANAESTHESIA IN GENERAL PRACTICE"*

MALCOM E. PHELPS, El Reno, Okla.

I am flattered to have been invited to this meeting of the Arkansas State Medical Society. It is indeed a pleasure to be here.

Since I am speaking on anesthetics I hope I am a good enough anesthesiologist to make this subject relatively painless, as if using a mild analgesia and yet not bore the audience to the point of anesthesia.

Since the earliest recorded history, man's quest for the relief of pain has been unending. Today with a wide range of agents to choose from, we are still searching for the perfect anesthetic.

It was in 1842 that Dr. Crawford W. Long of Georgia first used a general anesthetic to permit the carrying out of a major surgical procedure. Since that time we have come a long way in this field, as we have in other fields of medicine.

I believe all will agree that the development of present day medicine and surgery would never have been possible without the advent of anesthesia. At the present we all have our preferences and our prejudices of various types of anesthesias, based on individual experiences and the misfortunes we have witnessed. Often we do not stop to reflect that these vivid reflections of terrifying episodes may have been due to an unwise choice of agents or method for that particular patient or to an incomplete understanding of the special technique of administering these potent chemicals.

A study of statistics of anesthetic deaths reveals a startling situation. Records show that today death due to anesthetics occurs more than twice as often as occurred twenty years ago. In 500,000 anesthetics given in one hundred large University hospitals the death rate has been shown to be one for every 1,650. There are eight times as many deaths attributed to anesthesia yearly as there are to poliomyelitis, yet surprisingly little has been done to educate the medical profession to the dangers of various anesthetics and to use them wisely and cautiously.

The use of multiple agents to produce anesthesia appear to have caused this increase in the number of patients who die from cardiac failure and arrest, on the operating table and in the diagnostic examining's rooms.

Time will not permit detailed discussions of the special techniques of administration. All must understand the physiology and pharmacology of the anesthetic agents before they can hope to develop the proper skill in administering, and the careful selection of the safest anesthetic for the individual patient. Even after careful study we cannot hope to develop proficiency until we have had much experience and close observation in many patients. Even then, at times we will be confronted with entirely new and often bizarre reactions.

When one assumes the responsibility of administering an anesthetic he has contracted to provide not only good operating conditions for the surgical procedure but has obligated himself to conduct the anesthesic in the safest manner possible so as to least embarrass the patient's psychic and physiologic states.

Since there is no perfect anesthetic agent, the agent selected must fulfill as many desirable features as possible and yet be one with which the anesthetist is familiar, both as to the technique of administration and its pharmacologic properties, not only in healthy individuals but also in patients in whom the drug effect has been modified by some underlying pathology.

The anesthetist should make his choice after careful study of the patient and consultation with his surgical colleague. The agents and methods chosen must not increase any deviation from the normal already present, on the contrary, whenever possible the agent and methods used should have a corrective influence on the underlying pathology. Every patient has to be looked upon as a separate problem. Only in this way can mistakes be avoided and the agent and method selected that will be optimal for the given patient during the contemplated procedure.

First, let us take up local anesthetics, under which we will include topical, regional and spinal anesthetics.

As a rule topical anesthesia can be used only on mucous membranes.

Cocaine is probably the oldest drug in this group. It is very effective but its toxicity has lead to its becoming almost obsolete today. Fortunately the chemists have given us many substitutes which are satisfactory and safer than

* Read before the Seventy-eighth Annual Session, Arkansas Medical Society, Fort Smith, April 19, 1954.

cocaine, but the old adage that "the least toxic is still the most inefficient," applies today as it did many years ago.

Butyn, metaphen, diothane and similar drugs are widely used and are generally satisfactory and reasonably safe if properly used.

Freezing, as with ethyl chloride has a definite place in the armamentarium in minor surgery. In the lancing of abscesses and furuncles it is usually satisfactory if limited to these brief procedures. The freezing and thawing are somewhat painful but most patients are grateful for the use of this agent as it gives them confidence that the doctor is making every effort to cause as little pain as possible.

INFILTRATION: This is a very safe method if a few basic tenets are followed. It is somewhat time consuming and many patients are apprehensive and cooperate poorly. This is especially true in children. The danger of multiple punctures in infectious processes may lead to dissemination of infection so this method should be reserved for clean surgery, or at least where there is little danger of contamination. The outstanding virtue of this type of anesthesia is that it permits procedures in the elderly and the debilitated patient with a minimum of risk.

One minor disadvantage is the distortion of the region due to the ballooning of the tissues and the possibility that healing may be slowed. Care should be exercised that so much solution will not be used that it causes tissue necrosis due to compression of the blood supply to the injected area.

Procaine is still the "old reliable" in this type of anesthesia, although some of the newer agents have certain advantages. We believe that many of the reactions alleged to be due to the use of procaine may in reality be due to increased sensitivity of some patients to epinephrine, which is often added, or to emotional reactions and anxiety, rather than the procaine per se. In the past few years the use of procaine intravenously has substantiated this belief. Where necessary, ½% procaine may be used in amounts up to 300 cc. with comparative safety.

NERVE BLOCK: This is a very valuable addition to our armamentarium. Two per cent procaine is usually used but other drugs may be safely used as the amounts required are minimal. In fact, some of these newer drugs are frequently superior when the procedure takes more time than procaine block will give. The chief disadvantage of nerve block is that few of us are skilled enough in this technique. It is often difficult to place the anesthetic agent in close proximity to the nerve without damaging the nerve. We should all review our anatomy before we attempt to place a few cc's of a potent drug along the nerve sheath. I am sure that a few minutes spent in anatomical review will result in more successful nerve blocks.

Caudal anesthesia is in reality a "nerve block." In the hands of those skilled in its use it is not a difficult procedure, although there is at least a potential danger.

Continuous caudal anesthesia in OB's may be satisfactory in some large institutions where there is an abundance of skilled personnel, but I doubt if many of us have the time ourselves or can spare the trained assistant who must constantly be in attendance.

SPINAL ANESTHETIC: Contrary to popular belief this is a very old method, although it was not until about thirty years ago that it began to receive much attention. In the 1930's spinal block became very popular and by many was enthusiastically acclaimed. Today we believe it has been relegated to its proper role and has a place in our armamentarium. Now, even the most ardent advocates of spinal anesthesia grant that it should be employed only where operations are contemplated in the lower abdomen.

Because of many inaccurate stories and the early improper and unwarranted use of spinal anesthesia, a large number of patients rebel against the suggestion of its use. The most ardent supporters of this type of anesthesic are those patients who have undergone previous operations where spinal anesthetic was used.

It is well to remember that patients with either hyper-or hypotension are never good risks for spinal anesthesia.

Spinal anesthesia is of especial value in surgery of the intestines, particularly where obstruction with distention is present. Relaxation is obtained as with no other type of anesthetic. This relaxation permits the surgeon to accomplish his mission in a minimum of time with much less effort. This is one of its greatest attributes.

Caesarean section using spinal anesthetic permits the fetus to come into the world without being in the anesthetized condition present when any type of general anesthetic is used. This is of distinct importance. Spinal anesthesia below the tenth thoracic segment seldom causes serious circulatory disturbances, therefore is usually a safe method of anesthesia in the aged.

Spinal anesthesia is technically relatively simple to administer by any doctor who can do a

spinal puncture. But here again, even the most adept may at times have difficulties. The fact that the technique is so simple should in no way lead us to believe that we can trust an untrained assistant or nurse to administer the anesthetic. The surgeon that administers the anesthetic and then leaves someone other than a doctor to watch and check the patient is courting disaster.

Agents used for spinal anesthetics vary greatly in duration of action as well as in specific gravity. Some are lighter, some heavier, and some the same weight as spinal fluid. Knowing the properties of the anesthetizing agent is very important in controlling the height of the effect on the spinal cord. Disaster is imminent if one does not adhere strictly to these and other safe guards.

GENERAL ANESTHESIA: First, let us discuss the intravenous route. About 1930 sodium amytal was advocated as a general anesthetic but since it could not be well controlled it was not widely used. Various other barbituric acid derivatives were tried but it was not until the advent of sodium pentothal during World War II that this method was widely used. The fact that the bulk was small, could be easily transported and was not inflammable, made it a very fine adjunct to military medicine. Much of the emergency surgery done on, or adjacent to, the field of combat would have been impossible without the qualities it possesses. However, we feel that this type of anesthesia has very little place in the ordinary hospital. The danger of laryngeal spasm with asphyxia is well known. Sodium pentothal works beautifully as a basal anesthetic but it is difficult to understand why intravenous solutions should be employed when the same purpose may be accomplished if the patient is given a similar drug by mouth before scheduled surgery. Where the patient, for some reason, cannot swallow, or if the surgery must be immediate, it is of some value. If those enthusiastic persons who advocate wide spread use of intravenous anesthesia, either alone or in combination, will study the mortality tables, I believe their ardor will cool.

Rectal anesthesia has lost much of its popularity because its action is uncertain and cannot be well controlled. Frequently it becomes a messy affair, both to the patient and those in attendance.

INHALATION ANESTHETICS: Here we come to a wide variety of agents which have one factor in common, that is they are all volatile; some gaseous, some liquids. They are all absorbed through the alveoli of the lungs. Their action depends on the concentration in the blood stream, and they act directly on the higher centers of the nervous system. The hemoconcentration, necessary to produce anesthesia, varies widely as do the methods of administration. All have some advantages, all have some disadvantages. Inhalation agents have the primary advantages of being removable at will. If an overdose is given it may be removed by giving artificial respiration until the excess is eliminated. This flushing out of the anesthetic is not possible with any other types of anesthesia and therein lies the margin of safety these inhalation agents have. It must again be stressed that the experience and skill of the user has a great influence on their safety and effectiveness.

Ethyl chloride has very limited use as a general anesthetic. It is pleasant, the induction and recovery are rapid, but the margin between safety and dangerous concentrations is very narrow. If used it should be for only very short procedures, or induction, and must never be used except on an open mask.

Divinyl ether has much the same advantages as ethyl chloride but it has a wider margin of safety. It should be used chiefly for induction.

Chloroform is today almost an obsolete anesthetic agent. The fact that the margin of safety is not wide, as well as the fact that it may cause toxic changes in the liver or cardiac arrest, far out-weighs the fact that it is non explosive, pleasant, and gives good relaxation. For these reasons it is rarely used. At the present time the chief use is in OB's where mothers seem to have more tolerance to chloroform than other patients. It does give excellent analgesia when the pains of childbirth are severe. The small amounts necessary and the fact that it is non-inflammable makes it a useful aid in home deliveries.

Trilene has become popular recently. It should be administered by a special mask. Its chief value is its use in the early stages of labor. When used as an analgesia it is satisfactory. It is dangerous if complete anesthesia is required. When used with the special mask it is relatively safe. It should not be used in a gas machine where other agents have been used and must never be passed over soda lime.

Nitrous oxide is one of the oldest anesthetics. Its use as "laughing gas" for the exhilarating effect was known long before its use in surgery. When people were on some of these "laughing gas" jags, they noted that they felt no pain on falling or cutting themselves. The first demon-

stration of nitrous oxide as an anesthetic was at Massachusetts General Hospital in 1845 when a tooth was pulled before a large and skeptical audience. Because the patient cried out when the extraction took place these skeptics condemned nitrous oxide, even though the victim stated he felt no pain and did not remember what occurred.

With nitrous oxide a certain degree of anoxia is present. It is ineffective when more than 15% to 20% oxygen is added. For this reason it cannot be used when anemia or cardiac disease is present. It should be used only when the procedure will be of short duration or for induction. The induction is short and not unpleasant. Recovery is very rapid with a minimum hangover. Of course, it can only be used with a machine and any leaks in the machine of around the mask will destroy the effectiveness.

Nitrous oxide is probably most useful in obstetrics, where the mother can inhale a few breaths with each pain. This gives a very satisfactory analgesia. During the birth of the child the mother can be kept asleep and as soon as delivery is accomplished pure oxygen may be given. This prevents any deleterious effects to the infant due to anoxia. Another advantage of nitrous oxide is the fact that is is non-inflammable and not explosive.

Ethylene and cyclopropane are widely used. Both give good relaxation and adequate amounts of oxygen may be given with them. Both require the use of a machine. There is danger due to their explosive qualities. Even where extreme caution is used these occasional tragedies occur. These are always prominently reported by the press.

Ether, as previously mentioned, was the first agent used successfully for a major surgical procedure. Today it is the most widely used of all the anesthetic agents. During the 112 years since it was first used, it has been replaced in popularity many times by newer chemicals but after a trial most physicians return to the old reliable. It is almost impossible to determine how many thousands of patients have received ether anesthetics.

The disadvantages of ether are: The unpleasant odor and the fact that nausea often occurs. This may be lessened by proper preparation and unhurried induction.

Ether is both inflammable and explosive so should never be used around open flames or where it is necessary to use a cautery.

The so-called "ether pneumonia" has been shown to be largely a myth. In reality this is, at least in the beginning, an atelectasis. With proper preoperative preparation, ventilation exercises, and early ambulation, this is seldom seen today. However, we cannot overlook the fact that there is some irritation of the membranes of the respiratory passages when ether is used.

Other slight disadvantages are that it is bulky to transport and is not entirely stable after opening the container.

The virtues of ether are manifold but the most important attribute is that it is still the safest of all anesthetics. Ether is inexpensive and easily available. It may be used either in a machine or with a mask. It gives good relaxation. Adequate oxygenation is no problem. The blood concentration of ether necessary to produce respiratory paralysis is nearly two times that required to produce good surgical anesthesia. Impending disaster is trumpeted far in advance of its occurrences. When the anesthesia becomes too deep, a paralysis of the intercostal muscles occurs and the respiration becomes abdominal in type. It is fortunately much later that paralysis of the respiratory center occurs. Again it is still much later that the circulatory center is affected. The occasional inadvertent overdose seldom requires any corrective measure except the temporary interruption of administration. I am certain that all of us have seen instances where respiration ceased during ether anesthesia but the pulse continued strong. After the ether was discontinued respiration resumed and the operation was completed with no harm done except to those in attendance. After such an occurrence the anesthetist usually realizes that he should observe the patient and leave the details of the operation to the surgeons.

The very young and the very old are sensitive to oxygen lack and respiratory acidosis. They respond poorly to the sudden demands made on the circulation. In these, the agent of choice is still open drop ether.

Where a surgeon must use any available anesthetist and those who give anesthetics only occasionally, I am certain that most will insist on open drop ether because this time tested method is by far the least hazardous.

In conclusion I would like to emphasize a few points.

FIRST: Examine the patient carefully so that you will be appraised of all existing conditions.

SECOND: Study the physiological and pharmacological properties and the various proce-

dures of administering any anesthetic you contemplate using.

THIRD: When administering any anesthetic close attention must be kept on the patient so that if signs of danger occur they will be instantly noted and no time will be lost in instituting corrective measures.

A most helpful procedure, one that will make the induction smoother and the anesthetic more serene, is to spend a few minutes with the patient before surgery reassuring and instilling confidence in him. Fear and uncertainty increase the difficulties for both patient and anesthetist.

Finally the best anesthetic is the one with which you are the most familiar and that with which you have had the broadest experience.

The safety of an anesthetic is directly dependent on the care with which it is chosen and the skill used in administering it.

I hope that we will all develop more knowledge and skill in anesthesia so that our patients will be afforded the ultimate in safety and comfort that may be had from a wide choice of properly selected and expertly administered anesthetics.

I THANK YOU.

THE COMPLICATIONS OF CHOLECYSTECTOMY: PREVENTION AND TREATMENT*

THOMAS C. DOUGLASS, M.D.†

I have chosen to talk to you today concerning a topic which is regarded by many as being an "old chestnut." Cholecystectomy is ordinarily a relatively simple operation but one which may be as difficult as any surgical procedure in the abdomen. Complications of this frequently performed abdominal operation should be few in number but may be as serious as anything we encounter surgically today. It is in the interest of reducing the number and the seriousness of these complications that I wish to recount for you some of our experiences in handling a group of these cases.

I would like first to recall to you the complications which occur following any abdominal surgery and point out how they may be prevented.

Gastric dilatation may be prevented by the use of continuous gastro-duodenal suction. We routinely pass a Levin tube after the preoperative medication and apply continuous suction for 8 to 10 hours postoperatively. As a result patients practically never vomit and dilatation does not occur.

Urinary retention is looked for in every case. Failure to void or frequent urination of small quantities indicates catheterization early. We ask that female patients be catheterized in 6 to 8 hours if necessary. Male patients are allowed to stand by the bedside to void. If not successful the patient is catheterized.

Atelectasis is prevented by adequate bronchial aspiration at the conclusion of the anesthetic and early mobilization postoperatively. Encouraging the patient to cough effectively is also essential. Early ambulation has reduced this complication to a minimum in our experience.

Wound infections are infrequent following cholecystectomy today. With due care at surgery, drainage of the liver bed and the use of antibiotics where indicated we have had only 1% wound infections and none are serious.

Wound dehissance which occurs occasionally following any abdominal surgery has been reduced to nil by the use of the transverse incision. This incision also results in few postoperative herniae. We believe that there is less postoperative pain with this incision, particularly if the back rest is raised.

Pulmonary embolism has been no problem in this type case having occurred twice in a series of 720 cases studied in our hospital a few years ago and only one of these was fatal.

Complications Peculiar to Gallbladder Surgery

Cholangitis which is present preoperatively or occurs after exploration of the common bile duct may become serious postoperatively and usually manifests itself by producing a high fever with

* Read before the Seventy-eighth Annual Session, Arkansas Medical Society, Fort Smith, April 20, 1954.

† From the Department of Surgery, Northwestern University Medical School and Passavant Memorial Hospital.

or without chills. Treatment of this complication is first to make certain that there is free drainage through the drainge tube that has been placed in the common bile duct. Penicillin and streptomycin are usually effective antibiotics but in the more severe cases the broad spectum antibiotics such as aureomycin or terramycin have given dramatic results after penicillin and streptomycin have proven ineffective. It is our practice if the temperature is rather high and the condition of the patient is critical to give either intravenous aureomycin or terramycin immediately. These drugs are usually given in doses of 250 to 500 mgs. every 6 to 8 hours. A tip about the use of these drugs intravenously; we have found that phlebitis is less common if the drug is injected through the indwelling needle rather rapidly and then washed through by a continuously running infusion of saline or glucose. I would like to utter a word of caution about the performance of cholangiograms postoperatively in patients who have or have had a cholangitis. Severe recurrences of this condition upon any injection in the common bile duct are not uncommon. After complete subsidence of the infection, a cholangiogram should be performed before the indwelling tube is removed but should be done only several days to weeks after the subsidence of the infection.

Subphrenic abscess though rare has occurred, usually due to leakage from the biliary tract. It is prevented by drains and antibiotics. Treatment involves drainage and antibiotics.

The hepato-renal syndrome means to us hepatic and renal failure due to cholangitis, cirrhosis, or hepatitis. It should rarely occur in the properly prepared patient who is undergoing a cholecystectomy.

Injuries at Operation

The most serious complications of gallbladder surgery are due to injuries or accidents occurring during the operation. The prevention of these accidents should be foremost in the mind of the surgeon while operating on this portion of the anatomy. The variations in the anatomy found so frequently and so well described by Johnson and Anson[1] and Michels[2] indicate that the only safe course to pursue is the careful identification of all structures in the region before anything is clamped or cut. If this rule is followed in every case injuries will be few. Gentle dissection, the use of a fine aspirating needle, good lighting, wide exposure, and adequate assistance are essential features in gallbladder surgery.

Specific injuries may occur to the blood vessels or the bile ducts.

Hemorrhage is most commonly due to loss of the cystic artery. Laceration of the hepatic artery may occur and bleeding from the liver attachment may be severe. The hemorrhage due to prothrombin deficiency should be prevented by the adequate administration of vitamin K, 72 mgm. of hykinone daily is routine in our hospital. Compression of the hepatic artery between the thumb and index finger of the surgeon's left hand will control bleeding until the field can be made dry and the source of the bleeding ascertained. Cole has suggested that the foramen of Winslow be clearly identified before starting any dissection so that it is readily available in case of any emergency. Under no circumstances should a clamp be applied in a pool of blood since injuries are certain to result frequently if this is done. Suture of peritoneal flaps, left attached to the liver bed, controls the hemorrhage from this area quite well.

This subject naturally leads us to a consideration of the results of failure to follow the rules laid down above, that is, bile duct injuries. These injuries are being reported more and more frequently in the current literature. They need not occur and it is our duty as doctors to see that they do not.

Causes of bile duct injuries may be listed as poor lighting, inadequate exposure, insufficient assistance, hemorrhage, edema or induration about the ducts, anomalous position and haste. It goes without saying that the surgeon must assure himself that none of these factors are present when he removes a gallbladder.

Treatment of bile duct injuries discovered at surgery, may be a very difficult procedure. If the surgeon is experienced in such repairs the most effective reconstruction is the immediate end-to-end anastomosis of the duct about a tube used for drainage and as a splint. No tube, however, is to be led out through the anastomosis, rather through a vertical small incision below the site of injury. The reason for this is the dense fibrosis which occurs about any such wound. If the surgeon is not experienced in handling such an injury and an experienced surgeon is not immediately available for help it is far better to place a drainage tube in the proximal duct and lead this to the outside than to make an insecure anastomosis which leaks bile and results in such extensive fibrosis that subsequent reconstruction is rendered more difficult or impossible. The repair can then be performed at a time of elec-

tion on a patient who presents none of the hazards of an obstructed biliary tract.

The injury of the biliary tree discovered postoperatively is manifest by either jaundice or a biliary fistula or both. This situation requires the best preparation and the most painstaking surgery if the patient is to have a normally functioning biliary system. The preference of most surgeons doing this type of work is for an end-to-end anastomosis if this is at all possible. A choledochoduodenostomy is preferred in the cases not suitable for direct anastomosis and is effective if no obstruction is left at the stoma. The preference of some authorities for a Roux-en-y choledochojejunostomy is based on the hypothesis that cholangitis is due to reflux of duodenal contents into the biliary tree. We have not seen regurgitant cholangitis in cases with no obstruction. The production of an external biliary fistula and the Longmire procedure should be kept in mind for those cases too sick or too badly injured for the previously mentioned procedures. We have had great assistance in identifying ducts in severe injuries by operating room cholangiography.

A closely related complication though not always due to injury is bile peritonitis. The seriousness of this complication may not be appreciated due to a benign course but it is usually quite evident. The routine use of drains in the fossa will prevent this complication in the majority of cases. The slipping of a cystic duct ligature accounts for most such complications. An infrequent cause of bile peritonitis is leakage of bile after removal of the T-tube. The appearance of an extravasation of dye or the occurrence of pain during the performance of postoperative cholangiography should lead one to be cautious about removal of the T-tube. Removal should be delayed for another week or two if these incidents occur. It is also our practice to leave a Penrose drain in place for a day or two longer after removal of the T-tube.

Persistent symptoms following cholecystectomy have been well outlined and studied by Cole.[3] The causes are: wrong diagnosis, long cystic duct stump, remnant of gallbladder, overlooked common duct stone, fibrosis of the sphincter of Oddi, stricture of the common bile duct and biliary dyskinesia. The latter is purposefully placed last since we feel that all organic causes must be eliminated before a functional cause is diagnosed.

We have seen nine cystic duct remnants in two years and our experience is summarized in Table I. From this table it is seen that in nine patients the removal of the cystic duct remnant relieved the symptoms in only five. This study involved the use of a hospital controlled "fatty meal" test to aid in the diagnosis of such cases. Though helpful it is clear that almost half the patients had symptoms due to other causes.

Overlooked common duct stones are not frequent in our own experience, 3 in 150 patients in the past five years, and may be prevented by thorough exploration of the common bile duct for proper indications and by cholangiography. In our three cases the proper use of cholangiograms would have prevented this error. The use of routine cholangiography has produced a very high percentage of fruitful common duct explorations in our experience (75% in a recent study).

Fibrosis or stricture of the sphincter of Oddi is seen during cholangiography and a sphincterotomy is done on all cases showing obstruction of the duct at this point not accounted for by stones or tumor.

In conclusion the more common complications following cholecystectomy have been enumerated and the prevention and treatment of these complications has been outlined. The most serious complication of cholecystectomy is injury of the common bile duct. The prevention of this injury should be foremost in the minds of every surgeon doing biliary tract surgery. Following the simple but rigid rules of exposure, lighting, retraction and identification will prevent such injuries. The treatment of these injuries is outlined.

TABLE I

Cystic Duct Remnant Producing Post-Cholecystectomy Syndrome

Type of Pathology Found*	No.	Symptom-free**	Unimproved	Questionable
Redundant cystic duct stump with dense fibrosis				
a) With stones	1			1
b) Without stones	1	1		
c) With neuroma	1		1	
Redundant distended cystic duct stump	4	2	2	
Common duct stone and cystic duct stump	2	2		
Common duct stone	2	2		
Total	11	7	3	1

* Duration of symptoms 2-25 years.
** Duration of observation postoperatively 2-28 months.

BIBLIOGRAPHY

1. Johnston, E. V. and Anson, B. J.: "Variations in the Formation and Vascular Relationships of the Bile Ducts," Surg., Gyne. & Obstet., 94: 669-686, June, 1952.
2. Michels, N. A.: "The Hepatic, Cystic and Retroduodenal Arteries and Their Relation to the Biliary Ducts," Ann. Surg., 133: 503-524, 1951.
3. Cole, W. H., and Grove, W. J., Persistence of Symptoms Following Cholecystectomy with Special Reference to Anomalies of the Ampulla of Vater, Ann. Surg., 136: 73, 1952.

"SPARKS FROM THE SECRETARY"

J. J. MONFORT, Batesville

Just a reminder to you who may not have read this "Sparks From The Secretary" before; the word Sparks as a title for these ruminations were derived from the fact that the author, your secretary, has his nose to the grindstone and some sparks result.

The secretary had the pleasure of sitting in on the first arbitration committee meeting held in the state since the arbitration committee, under the capable leadership of Dr. H. E. Mobley of Morrilton, (through his work as chairman of the Industrial Health Committee) has been organized. The matter involved was a matter in our district in which a doctor had been lax in turning in insurance reports and the insurance man had been pressuring him in somewhat unusual manner for the report. The worst of the whole thing is that it was unnecessary if the doctor had merely attended to business.

Annual Session

The attendance, of course, as will be reported elsewhere was excellent; almost as good as when the session is held in the middle of the state. The scientific program, under the chairmanship of Fount Richardson, was most excellent. I do not see how you could ask for a better program, it was well outlined, well presented, and the speakers were chosen with exceptional care. I did not hear a bad program on the entire meeting. It is somewhat to our shame, of course, that some of the programs were not as well attended as they should have been, but that is a matter for the conscience of each doctor and all I can say is that there are a great many of us that should have a guilty conscience for missing some good lectures. The outstanding speaker, possibly of the program was Dr. Ross of North Carolina. A Gynecologist of note, Dr. Ross is one of the most entertaining speakers, who still gets his points across and speaks with most excellent good sense, of all speakers I have heard and I have heard many. The Rockefeller project, of course, was quite interesting and should be full of interest to all of us. Just this week from the A.M.A. Secretary's Letter, we note that we got quite a writeup; this goes to all the Medical Society Officers in the U. S. on this matter. Dr. Hundley and Dr. Nicholson and other men have worked very hard on this project and it is just now shaping up to where some more real work can be done. We certainly congratulate Mr. Rockefeller upon his most excellent common sense. I assure you, if you had heard him, you would have a very high respect for the man's experience and intelligence in these matters.

The meeting is to be at Hot Springs next year and Dr. King Wade, Jr., I understand, and his co-workers are already making some plans in that respect. Of course, we have to wait until a little later in the year to have it at the Arlington Hotel, but we all know it will be well worth waiting for. Randolph Ellis has a picture of which I certainly wish to get a copy; that of our new president, the Ebullient Bill Brooksher, being "escorted" to the rostrum after his nomination and election, in fact three of the characters (past presidents) carried Bill to the rostrum like a pig being carried to slaughter. That might not be such a bad simile at that!

FIFTY-YEAR CLUB BREAKFAST

April 20, 1954

By M. L. NORWOOD, Presiding

Amid aroma of good food provided by the thoughtfulness and generosity of the parent society, and good fellowship of twenty-club members we had a jovial fine time and an instructive talk by that genial fine gentleman, D. W. Goldstein of Fort Smith, on "Medicine of Fifty Years Ago," and "Up to the Present Time." A talk we all understood and appreciated. This talk was clinched by L. H. McDaniel. The Society's well-known attorney, Hon. Peter Deisch, gave the invocation for the meal. We were delighted to have him as our guest.

Will H. Mock, Prairie Grove, gave an impressive address for the Memorial Services for the following deceased members:

A. L. Best, Newport; T. L. Hodges, Bismarck; M. C. Hawkins, Parkdale; A. S. Buchanan, Prescott; M. W. Duncan, Centerton; T. S. Jordon, Magnolia; D. A. Mohler, Forrest City; S. D. Weil, Hot Springs; W. B. Reasons, Hermitage, and E. F. Brewer, Augusta.

The following officers were elected for 1955: President, C. W. Dixon, Gould; Vice-President, Will H. Mock, Prairie Grove; Secretary, J. H. McCurry, Cash.

J. H. McCurry, Secretary.

OBITUARY

GEORGE R. STORM, age 64, Helena physician, died suddenly at his residence in Waverly Woods, April 8. Death was attributed to a Coronary Occlusion.

Born in Brookhaven, Mississippi, Dr. Storm moved to West Helena in 1923 and had practiced in the Twin Cities since that time. He was well known throughout Eastern Arkansas as a physician and surgeon.

He was a member of the Phillips County Medical Society, the Arkansas Medical Society, and the American Medical Association. A veteran of World War I, he was also a member of the Richard L. Kitchens Post, American Legion.

Dr. Storms is survived by his wife, Mrs. Lula Green Storm and a step-son, Walter Moore, both of Helena.

★ Editorial ★

This Journal is published under the direction of the Council of the Arkansas Medical Society, and its editors are responsible for its conduct to the Council. Behind the Council, and supporting it, are the members of the Arkansas Medical Society, so that in the final analysis, the Journal becomes the organ of the Society's membership.

By this token, the Journal attempts to represent the thought and aspirations of the composite membership. It avoids political controversy and private differences. But, it will, by no means, stand idle when the grasping hand of outside control seeks to take over the prerogative of medicine, whether this be the Federal government or political pressure groups. This Journal will not be silent when hospitals encroach on the private practice of medicine, or when groups seek to gain pecuniary advantage or mandatory control of medicine by illegal or unethical practices. It will not remain quiet when interference with the private practice of medicine appears, on any quarter, and it will champion the friendly relationship of the man who is ill, with the personal physician that he has freely chosen.

These thoughts above are but a continuation of the policy of the Council and its editors for the past twenty years. The Journal has during this time been directed and edited by the able W. R. Brooksher.

In the twenty years that he has been our editor, the Journal has grown with the Society. But it has grown in other ways. Brooksher has become one of the most influential men in America in the American Medical Association and in the Society of Medical editors. His restless nature has been trained into channels which have produced stability in Arkansas Medical circles, where he is a proven leader. His contagious enthusiasm has been the stimulus which has kept the Journal and the Arkansas Medical Society up to date and a force and an influence in medical circles throughout America. He and Arkansas' other outstanding medical leader, R. B. Robins, of Camden, share high distinction in organizational work in many other medical societies.

It is with some reluctance that one sees Dr. Brooksher give the editorship to other hands. It is fitting that in leaving that post that he goes to the place of highest honor that can be given by Arkansas physicians. The Journal salutes Dr. W. R. Brooksher, President of the Arkansas Medical Society.

PUBLIC RELATIONS

Physician
Patient
Personal

HEALTH INSURANCE

The amazing development of voluntary Health Insurance plans in the United States during the past fifteen years is probably the most potent weapon of the medical profession in the fight against Federal Compulsory Insurance or other governmental-controlled medical plans. As members of a profession which is based on free initiative and freedom of choice we should exert all our influence in support of voluntary hospital, surgical and medical insurance coverage. We should take time to explain to our patients the advantages of this voluntary participation over a political compulsory program.

In 1941 only 16 million persons had some hospital or medical insurance; today approximately 100 million of us are protected. We must help those in the insurance field continue to expand this coverage. Especial attention should be paid to the needs of the elderly and those suffering from the chronic or "catastrophic" illnesses or injuries. Much is being accomplished along this line even at this time.

As practicing physicians we can best aid the voluntary health insurance program by the prompt discharge of our professional responsibilities. Most busy doctors dislike paper work and forms to be completed. However, we are obligated to our patients and to the insurance carrier to complete the forms accurately and return them promptly. Our charges must be reasonable. There should be no difference in fees just because the patient had the judgment and foresight to protect himself by insurance.

In Arkansas the Workman's Compensation Act is efficiently filling a great need in the protection of workers injured while employed. Here again we must render the best medical care, return accurate reports promptly and submit reasonable charges.

All things being equal such as competency, accuracy and promptness of the practitioner, an injured workman, the same as any other patient, ought to be able to choose his own family physician to care for him. This freedom of choice should prevail if employees be instructed to request their personal physician in case of injury.

C. L. Hyatt.

TUBERCULOSIS ABSTRACTS

A Review for Physicians

ISSUED MONTHLY BY THE NATIONAL TUBERCULOSIS ASSOCIATION

A COMPARATIVE ANALYSIS OF THE POST-DISCHARGE EXPERIENCES OF TUBERCULOUS PATIENTS

By SOL L. WARREN, Ph.D., The American Review of Tuberculosis, February, 1954.

Vocational rehabilitation, as an organized program of public aid to the physically handicapped, had its inception in this country some thirty-odd years ago. There is general acceptance of the program, yet its definitive values remain essentially unconfirmed. The recognition of the need for systematic research in this field prompted the evaluative study described in the present report.

The objectives of the study were: to discover whether differences could be discerned between a group of persons who participated in a vocational rehabilitation program and a comparable group who did not participate in such a program; to determine, if any such differences were found, their nature, extent, and significance to the individual, the rehabilitation agency, and the community.

The most important characteristic of the study was its method of approach in setting up controlled conditions. Scrupulous attention was given to the three primary demands of scientific analysis in causal-comparative research. These include: verification of the comparability of experimental and control groups prior to the introduction of the experimental variable; maintenance of uniform conditions during the experiment; and the demonstration by valid statistical techniques of the significant differences between the groups.

Two hundred and fifty-seven patients discharged from Municipal Sanatorium of New York City at Otisville, New York during 1942 and 1943 were selected because they met the following criteria: they were first admissions to the hospital who had been discharged with medical consent as having arrested tuberculosis; they were all on four-hour activity tolerance, had favorable prognoses, and needed rehabilitation assistance; they were of equivalent economic status; they had been processed through the sanatorium rehabilitation program.

Following discharge, these patients separated into two groups as some availed themselves of the services provided by the state agency whereas others did not. On the fifth anniversary of discharge from the sanatorium, both groups were interviewed. Additional data were obtained from clinics, hospitals, physicians, social agencies, friends, relatives, and employers. Of the 257 patients selected for the study, 240 were located and included. The remaining 17 could not be found or refused to cooperate. Of the 240 subjects studied, 79 participated in the state agency's program while 161 failed to take part.

The opposing groups were compared with respect to their pre- and post-discharge characteristics and experiences. Criteria of comparison included factors commonly associated with physical, emotional, social, economic, and vocational adjustment.

A pre-discharge comparison of the participating and non-participating groups disclosed their equivalent with respect to every criterion measured. Among these were such factors as age, sex, color, religion, place of birth, and citizenship status. Socio-economic factors such as marital status, number of dependents, source of income, public welfare experience, and contacts with social agencies, the highest school grade completed, in-sanatorium activities, psychological test results and personality characteristics were also equated. Under physical data, the comparison covered family and personal tuberculosis history, the clinical status, activity tolerance, and prognosis. Included among the vocational factors were length of work history and number of occupations and jobs held. A detailed comparison was made of the last pre-sanatorium job.

On the basis of the pre-discharge analysis, it was concluded that, at the point of discharge from the sanatorium, the participating and non-participating groups were comparable in every meaningful respect. This equivalence provides a

valid basis for conclusions bearing on the post-discharge experiences of the groups.

The post-discharge analysis compared the groups with respect to all pertinent factors mentioned above plus many others. The findings disclosed more favorable outcomes for the participating group in virtually every aspect investigated. Only the more significant ones are summarized here.

The participants exhibited considerably lower mortality and relapse rates than the non-participants. Although of comparable physical status at the time of discharge, at follow-up examination those who had received rehabilitation assistance were uniformly better off than their non-participating counterparts. Although both groups earned approximately the same wages in their last pre-sanatorium jobs, the participants entered initial post-discharge jobs at decidedly lower wages than did the non-participants. When wages were recorded at the end of the five-year period, the participants had forged ahead quite conclusively.

Without presenting details, it is recorded here that the jobs held by the participants were almost invariably better than those held by the non-participants. Such items as days and hours of work, total earnings, number of wage increases and promotions, job tenure, sick-leave provisions, employer awareness of the tuberculous background, and absenteeism were considered.

On the basis of the findings disclosed by the present study, it may be concluded that participation in the vocational rehabilitation program produced consequences which were definitely significant to the persons who participated, to the rehabilitation agency which provided the services, and to the community as a whole.

In terms of individual experiences, participation in the program produced certain specific outcomes. In encouraging adequate convalescence and attention to medical advice, in discouraging premature resumption of employment, and in promoting suitable vocational objectives, it contributed significantly to the attainment and maintenance of normal health. In helping by supportive and tangible assistance to overcome the psychologic trauma associated with tuberculosis it contributed to the restoration of normal life patterns. In furnishing sound occupational guidance, adequate job preparation, placement assistance, and close supervision of employment, it contributed to satisfactory vocational experience in occupations, commensurate with mental levels, interests, aptitudes, education, work background and physical capacities. By providing useful skills in remunerative fields it contributed to the restoration of financial independence. In creating an advantageous physical, emotional, vocational, and economic climate, it contributed to the assumption of the community and family obligations which are essential to social and personal adjustment.

The findings substantiate the economic soundness of the rehabilitation program and provide the basis for future development and expansion.

Finally, in terms of community involvement, the findings are significant because they provide facts which should enlighten the public and management regarding the proficiency, stability, and vitality of ex-tuberculous workers properly placed. They demonstrate the practical and tangible benefits to the community in terms of tax returns and purchasing power and in savings in welfare and hospitalization costs. They point the way to a happier citizenry through the promotion of economic self-sufficiency, physical and emotional well-being, social and vocational adjustment, and general personal contentment.

PROCEEDINGS OF SOCIETIES

The Hot Spring County Medical Society was addressed March 16th by John Harrell, Little Rock, on "Emotional Problems in Children and Their Treatment." Raymond E. Peeples, Malvern, was host to the society.

The Independence County Medical Society met Monday, April 12, at the Batesville Country Club in conjunction with the Auxiliary for a dinner meeting. The scientific session was conducted by the President, Meryl Grasse, and an exceptional program was offered by Frank Kumpuris and Bill Dave Stewart of Little Rock. They made a new and a very interesting presentation of the "Six Dam Subjects." Their presentation was accompanied with visual education in such a manner that it was quite interesting and was enjoyed by all. Mrs. Kumpuris and Mrs. Stewart were present to visit with the ladies during the Auxiliary meeting.

The Sixth Annual Assembly of the Arkansas Academy of General Practice was held in Fort Smith April 19th with the following program: "President's Address," J. M. Kolb, Clarksville; "On Medicine in Mexico," J. H. Ross, Michoacan, Mexico, and "The American Academy of General Practice: Its Motives, Its Future," Malcolm E. Phelps, El Reno, Oklahoma. The follow-

ing officers were elected: President, C. R. Ellis, Malvern; President-Elect, Ben Saltzman, Mountain Home; Secretary-treasurer, C. C. Long, Ozark; 1st Vice-president, Wm. A. Snodgrass, Little Rock, and 2nd Vice-president, Lamar McMillin, Little Rock.

PERSONALS AND NEWS ITEMS

George Mallory has moved offices from Rose City to North Little Rock.

The second annual meeting of the Arkansas Mental Health Society was held in Little Rock, May 7.

"Senior Medical Day" was inaugurated in Little Rock on May 14, honoring the Seniors in the University of Arkansas School of Medicine. It was sponsored by the Arkansas Medical Society and the Arkansas Academy of General Practice.

W. P. Barron, a native of Harrison, has returned there to open his office at 707 N. Vine. His special interest is Pediatrics.

W. J. Butt, Fayetteville, made a business trip to Illinois with the University of Arkansas baseball team recently.

Chas. E. Oates, Little Rock, has been appointed a member of the Arkansas Basic Science Board.

Diagnostic cancer clinics were conducted recently under the joint sponsorship of the local medical society and the Arkansas Division, American Cancer Society at Mena: D. W. Goldstein, M. B. Hoge, John Wood and L. K. Williams; at Ozark, D. W. Goldstein, James Thompson and W. R. Brooksher, and at Perryville; Calvin Dillaha and Bill Stewart.

Dr. and Mrs. Harry E. Murry, Texarkana, spent three weeks in the Hawaiian Islands following the New Orleans Clinical Assembly.

Louis Hundley, Pine Bluff, was named district governor of South Arkansas District Rotary Clubs at their annual meeting in Hot Springs, May 6.

R. B. Robins, Hayden C. Nicholson, and R. C. Dickinson were the featured speakers at the University on Pre-Med Day, April 30.

H. J. Mayfield has been elected surgeon-general of the El Dorado post, AMVETS.

Courses in Internal Medicine were offered for a two-day postgraduate program, May 5-6, at the School of Medicine in Little Rock. Fourteen hours of credit is given its members by the Arkansas Academy of General Practice for attendance at this course. Speakers and sponsors were:

James T. Wortham	James E. Doherty
Elmer Purcell	S. William Ross
Andrew J. Moriarity	William K. Jordan
Alan G. Cazort	Robert W. Talley
W. S. Abbott	Habid Sadik
James S. Taylor	Harold R. Hipp

An announcement from Mitchell, South Dakota, informs us that twin sons were delivered to Mrs. Preston Brogdon on May 4. Preston Brogdon moved from his office at Springdale last year.

Art B. Martin and Louis Lambiotte, Fort Smith, have been elected associate fellows of the American College of Physicians.

Peter O. Thomas, Little Rock, attended the meeting of the Hodgen Surgical Travel Club in New Orleans during April.

H. M. White has been elected president of the Rogers Lions club.

Max McAlister has been elected surgeon of the Fayetteville post, Veterans of Foreign Wars.

F. Walter Carruthers, Little Rock, left for an European tour May 5th and will attend meetings of the Royal College of Surgeons in London and the International Surgical Society in Paris.

F. Walter Carruthers, Little Rock, has been elected a director of the Mid-Central States Orthopedic Society.

O. J. T. Johnston, Batesville, attended the Dallas Southern Clinical Society meeting on March 15, 16, 17, and 18.

J. K. Grace, recently returned from Japan, addressed the Pope-Yell County Medical Society in May.

Amebiasis[1] a "Poorly Reported" Disease

Until serious complications arise, amebiasis may pass unrecognized and patients receive only symptomatic treatment.

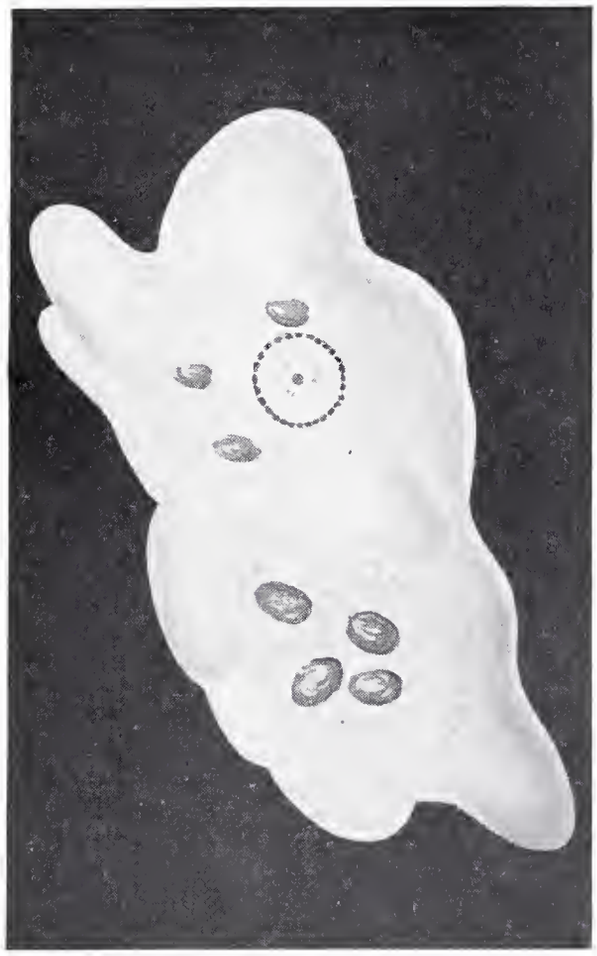
Although amebiasis is a disease with serious morbidity and mortality, statistics on its incidence[1] are incomplete because its manifestations are not commonly recognized and consequently not reported.

"*Vague symptoms[2] referable to the gastrointestinal tract, such as indigestion or indefinite abdominal pains, with or without abnormally formed stools, may result from intestinal amebiasis. Not infrequently in cases in which such symptoms are ascribed to psychoneurosis after extensive x-ray studies have been carried out, complete relief is obtained with antiamebic therapy.*"

To prevent possible development of an incapacitating or even fatal illness and to eliminate a reservoir of infection in the community, diagnosing and treating[3] even seemingly healthy "carriers" and those having mild symptoms of amebiasis is advised.

Early diagnosis[1] is important because infection can be rapidly and completely cleared, with the proper choice of drugs and due consideration for the principles of therapy. For treatment of the bowel phase these authors find Diodoquin "most satisfactory."

For chronic amebic infections, Goodwin[4] finds Diodoquin to be one of the best drugs at present available.



Endamoeba histolytica (trophozoite).

Diodoquin, which does not inconvenience the patient or interfere with his normal activities, may be used in the treatment of acute or latent forms of amebiasis. If extraintestinal lesions require the use of emetine, Diodoquin may be administered concurrently. It is a well tolerated and relatively nontoxic orally administered amebacide, containing 63.9 per cent of iodine.

Diodoquin (diiodohydroxyquinoline), available in 10-grain (650 mg.) tablets, reduces the course of treatment to twenty days (three tablets daily). Treatment may be repeated or prolonged without serious toxic effect. It is accepted by the Council on Pharmacy and Chemistry of the American Medical Association. G. D. Searle & Co., Research in the Service of Medicine.

---

1. Hamilton, H. E., and Zavala, D. C.: Amebiasis in Iowa: Diagnosis and Treatment, J. Iowa M. Soc. *42*:1 (Jan.) 1952.

2. Goldman, M. J.: Less Commonly Recognized Clinical Features of Amebiasis, California Med. *76*:266 (April) 1952.

3. Weingarten, M., and Herzig, W. F.: The Clinical Manifestations of Chronic Amebiasis, Rev. Gastroenterol. *20*:667 (Sept.) 1953.

4. Goodwin, L. G.: Review Article: The Chemotherapy of Tropical Disease: Part I. Protozoal Infections, J. Pharm. & Pharmacol. *4*:153 (March) 1952.

The following participated in the program of the Arkansas Society of Medical Technologists at its Fort Smith meeting April 23-25th: A. S. Koenig, Fort Smith; A. A. Blair, Fort Smith; R. H. Chappell, Texarkana; Roger Bost, Fort Smith; D. W. Goldstein, Fort Smith; E. Z. Hornberger, Fort Smith; M. J. Kilbury, Little Rock, and Carroll Shukers, Little Rock.

May 20 was the unusual occasion of the First Councilor District Medical Society Meeting combined with the L. H. McDaniel program and barbeque. More than 300 guests heard a galaxy of medical talent gathered in Tyronza from all corners of the United States.

W. G. Cooper and E. C. Cope of Little Rock held a Cancer Clinic with local physicians, Ben Saltzman and H. K. Baldridge, in Mountain Home on May 7.

S. W. Hawkins, Fort Smith, was a featured speaker at the Louisiana State Medical Society which met in New Orleans recently.

The American Medical Education Foundation announces receipt of contributions from the Bowie-Miller and Garland County Medical Society Auxiliaries during April.

WOMAN'S AUXILIARY NEWS

The Woman's Auxiliary to the Jefferson County Medical Society sponsored a panel discussion entitled "Your Rx for Mental Health" at the Lakeside School Auditorium on Friday night, January 22, 1954.

The four members of the panel represented the several viewpoints and attitudes of the approach to mental health. Dr. Edmond P. Erwin, clinical psychologist and Assistant Professor in the Department of Psychiatry at the University of Arkansas School of Medicine, acted as moderator for the discussion. He was assisted by Dr. Guy Zimmerman, Jr., psychiatrist and Clinical Director of the State Hospital for Nervous Diseases; the Reverend Mr. T. P. Devlin, Rector of the Trinity Episcopal Church, Pine Bluff; and Miss Juanita Baldwin, Guidance Counselor, Pine Bluff Junior High School.

Mrs. Hunter A. Causey, president of the Auxiliary, welcomed the guests and the speakers. Dr. R. E. Glasscock spoke briefly on the need for better public understanding of the many facets of the problems concerning mental health, and introduced the members of the panel to the audience.

Following an introductory film on a case example of mental health detection and treatment, Dr. Erwin directed leading questions to the panel which brought out a discussion of the various types of mental illnesses by Dr. Zimmerman. The psychological problems of adolescent students and their possible guidance was explained by Miss Baldwin. The Reverend Mr. Devlin, present chairman of the Welfare Committee of the Pine Bluff Community Chest, emphasized the need for a local child guidance and family counselling agency, and revealed that the Community Chest plans to conduct a survey in an effort to determine the possibility and feasibility of establishing such an agency here.

Plans for the Eighth Annual Benefit Tea and Style Show to be held next month at the Hotel Pines were perfected. Co-chairmen for the event were Mrs. Clyde Hart, Jr., and Mrs. R. E. Glasscock.

Following the meeting Dr. and Mrs. Causey held open house for the guest speakers and their wives, Auxiliary members and their husbands.

The meeting was arranged by Mrs. R. E. Glasscock, Public Relations chairman, with 500 invitations mailed to individuals, school, church and civic organizations. Mrs. Howard Stern, Health Education chairman, made all arrangements for obtaining the speakers and general planning of the discussion. Newspaper, television, and radio publicity were handled by Mrs. W. J. Wilkins, Jr., Publicity secretary. The discussion was recorded and later broadcast by radio station KOTN.

U. C. MEDICAL CENTER LIBRARY
JUL 23 1954
San Francisco, 22

JULY 1954

THE JOURNAL OF THE ARKANSAS MEDICAL SOCIETY

VOL. LI NO. 2

FORT SMITH, ARKANSAS

FOURTH ARKANSAS RURAL HEALTH CONFERENCE
LITTLE ROCK, JULY 20-21

sustains contraction of postpartum uterus

'Ergotrate Maleate'
(ERGONOVINE MALEATE, U.S.P., LILLY)

to prevent hemorrhage, lessen risk of infection

IN 1/320-GRAIN TABLETS AND AMPOULES

in epilepsy,

Given social acceptance,

the great majority of

epileptic patients

can lead normal lives

DILANTIN, after more than 15 years of clinical experience, is an established anticonvulsant of choice. Its ability to control grand mal and psychomotor seizures, without the handicap of hypnosis, helps many epileptic individuals participate in normal educational, economic, and social activities.

Dilantin® Sodium

(diphenylhydantoin sodium, Parke-Davis)

DILANTIN Sodium is supplied in a variety of forms—including Kapseals® of 0.03 Gm. (½ gr.) and 0.1 Gm. (1½ gr.) in bottles of 100 and 1000.

MEDICAMENTA VERA

Parke, Davis & Company

DETROIT, MICHIGAN

THE

Journal

OF THE

Arkansas Medical Society

Owned by

THE ARKANSAS MEDICAL SOCIETY

And Published Under Direction of the Council

FOUNT RICHARDSON, M.D., Editor

316 West Dickson Street Fayetteville, Arkansas

MR. PAUL C. SCHAEFER, Business Manager

215 Kelley Bldg. Fort Smith, Arkansas

The Advertising policy of this JOURNAL *is governed by the rules of the Council on Pharmacy and Chemistry of the American Medical Association.*

EXCLUSIVE PUBLICATION—Articles are accepted for publication on the conditions that they are contributed solely to this JOURNAL.

COPYRIGHT, 1954—By The JOURNAL *of the Arkansas Medical Society.*

NEWS—Our readers are requested to send in items of news, also marked copies of newspapers containing matter of interest to the membership.

OFFICERS OF THE ARKANSAS MEDICAL SOCIETY

W. R. BROOKSHER, President....Fort Smith
L. H. McDANIEL, President-Elect....Tyronza
T. P. FOLTZ, First Vice-President....Fort Smith
ELDON FAIRLEY, Second Vice-President....Wilson
R. H. WHITEHEAD, SR., Third Vice-President....DeWitt
J. J. MONFORT, Secretary....Batesville
DANIEL H. AUTRY, Treasurer....Little Rock
T. DUEL BROWN, Speaker, House of Delegates....Little Rock
C. C. LONG, Vice-Speaker....Ozark
MR. PAUL C. SCHAEFER, Executive Secretary
215 Kelley Bldg., Fort Smith

COUNCILORS

First District—JOE VERSER....Harrisburg
Second District—HUGH R. EDWARDS....Searcy
Third District—J. MAX ROY....Forrest City
Fourth District—L. K. HUNDLEY, Chairman....Pine Bluff
Fifth District—D. E. WHITE....El Dorado
Sixth District—HARRY E. MURRY....Texarkana
Seventh District—H. KING WADE, JR....Hot Springs
Eighth District—H. ELVIN SHUFFIELD....Little Rock
Ninth District—FOUNT RICHARDSON....Fayetteville
Tenth District—J. M. KOLB....Clarksville

VICE-COUNCILORS

First District—WAYNE WORKMAN....Blytheville
Second District—JOHN SNEED....Conway
Third District—J. P. WILLIAMS, JR....Brinkley
Fourth District—H. W. THOMAS....Dermott
Fifth District—GEORGE BURTON....El Dorado
Sixth District—CHARLES YARBOROUGH....Texarkana
Seventh District—RANDOLPH ELLIS....Malvern
Eighth District—ROBERT D. JONES....Little Rock
Ninth District—LEE A. DEAN....Rogers
Tenth District—LOUIE A. WHITTAKER....Fort Smith

Notice on Form 3578-P to be sent to the Arkansas Medical Society, 215 Kelley Building, Fort Smith, Arkansas. Published monthly under direction of the Council, Arkansas Medical Society, at Fort Smith, Arkansas. Vol. LI. No. 2. Subscriptions $3.00 a year. Single copies, 50 cents. Entered as second-class matter, Sept. 23, 1947, at the post office at Fort Smith, Arkansas, under the Act of Congress of March, 1879. Acceptance for mailing at special rate of postage provided for in Section 1103, Act of October 3, 1917, authorized August 1, 1918.

- SPECIAL FEATURES

Differential Diagnosis of Organic and Functional Disorders of the Intestine 39

General Practice in Rural Mexico.. 47

The Challenge of General Practice 50

- FEATURES

Editorial 52

Tuberculosis Abstracts 53

Obituary 55

Proceedings of Societies 56

"Sparks From the Secretary" 57

Personals and News Items..... 57

Women's Auxiliary 60

Book Reviews 60

The JOURNAL
OF THE ARKANSAS MEDICAL SOCIETY
PUBLISHED MONTHLY UNDER DIRECTION OF THE COUNCIL

Vol. LI July, 1954 No. 2

DIFFERENTIAL DIAGNOSIS OF ORGANIC AND FUNCTIONAL DISORDERS OF THE INTESTINE*

E. G. WAKEFIELD, M.D.
Section of Medicine, Mayo Clinic and Mayo Foundation †
Rochester, Minnesota

The definition of organic disease implies a departure from health caused by a gross or histologic disruption of the organized structure of an organ or organs. The diagnosis of organic disease does not necessarily imply that the manifestations are directly referable to the affected organ or organs. Indeed, organic disease can be manifested locally in the affected organ, generally in the system to which the organ belongs, and constitutionally, that is, it can affect the body as a whole. A distinguishing feature of organic disease is its orderly inception and its progress to a predictable conclusion. The variations in the conclusion of an organic disease may be changed during its progress by incidents which favor or hinder its progress, and these incidents also are predictable.

The definition of a functional disorder or disease implies a departure from health which is not caused by gross or histologic disruption of the structure or homeostasis of any organized tissue or tissues of the body. The diagnosis of a functional disorder implies that the symptoms are not strictly limited to an organ, tissue or system, except in cases of obsessive neurosis. A distinguishing feature of a functional disorder is its inorderly inception and its progress to an unpredictable conclusion.

There is a middle group of disabilities which preferably are not classed as either organic diseases or functional disorders. I am referring here to extraordinary disruption of function occurring in association with or subsequent to proved organic disease or severe emotional trauma. These cause excessive weakness of body musculature manifested by a reeling or ataxic gait, breathlessness, tachycardia, blurred vision, poor appetite and constipation. These disruptions are constitutional caprices.

* Read at the meeting of the Arkansas Medical Society, Fort Smith, Arkansas, April 20, 1954.
† The Mayo Foundation is a part of the Graduate School of the University of Minnesota.

Organic Diseases of the Intestine

A patient who seeks relief from organic disease of the intestine, as well as the one who seeks relief from a functional disorder of the intestine, complains of abdominal pain or of discomfort and irregularity of intestinal function. Experience teaches us that the most successful diagnostician has in mind an orderly, systematized accumulation of facts which he employs in order to make the proper diagnosis quickly when confronted with an ambulatory patient complaining of abdominal discomfort or pain associated with either constipation or diarrhea. The following paragraphs briefly present a workable outline which will be helpful in the diagnosis and differential diagnosis of the organic diseases of the intestine.

The following organic disorders of the intestine must be distinguished from functional disorders: (1) congenital malformations, (2) infections and infestations, (3) the allergic state, (4) hormonal disorders, (5) diseases of unknown origin, and (6) neoplasms.

Congenital Malformations.—Congenital malformations of the intestine include failure of rotation or fixation, aberrations in the size of the lumen, excessive length, diverticula, ectopic tissue, and kinks and bands.

Failure of Rotation or Fixation.—Failure of rotation or fixation of the intestine may not cause any symptoms until solid foods are consumed or until later in life. Usually, these anomalies do not cause any symptoms. They are recognized as curiosities which are compatible with good intestinal health. Failure of fixation may be associated with a volvulus, which constitutes an acute abdominal emergency.

Aberrations in the Size of the Intestinal Lumen.—Variations in the size of the intestinal lumen are manifested in infancy or childhood. Atresia produces symptoms of intestinal obstruction immedi-

ately after birth. Atresia may occur in the esophagus, duodenum, rectum or anus, and the manifestations vary according to the site of the anomaly.

A congenital stricture may not cause symptoms until childhood or adulthood. It may not become obvious until an organic disease develops. For example, a stricture of the esophagus may not cause any symptoms until the involved portion of the esophagus has been injured secondarily by the ingestion of a corrosive substance.

Excessive size of the intestinal lumen is designated by the prefix "mega." For example, the term "megacolon" is used to designate an abnormally large colon. The best known example of this anomaly is Hirschsprung's disease. In cases of this disease, it is observed early in infancy or childhood that normal bowel movements seem to be impossible. Examination reveals that the entire colon or parts of it are enlarged and contain impacted feces. Administration of laxatives may result in the passage of small amounts of feces which seem to pass around or through the impaction. If laxatives are not administered, the patient will not have a bowel movement for days or weeks. The abdomen enlarges, and there is a rapid failure of health. Roentgenologic examination may reveal that only the sigmoid is involved. If the disease is of long duration, it usually involves the entire colon.

Excessive Length.—Excessive length of the intestine is designated by the roentgenologist with the prefix "dolicho." For example, the term "dolichosigmoid" is used to indicate that the sigmoid is too long. Excessive length of the intestine may predispose to volvulus, but it rarely causes any symptoms.

Diverticula.—Diverticula situated in any part of the intestine do not cause hemorrhage unless they contain ectopic tissue. Diverticula of the duodenum and of other parts of the small intestine usually are asymptomatic. Diverticula of the colon may become infected, and the ensuing diverticulitis, if uncomplicated, causes symptoms similar to those of appendicitis. These include such generalized symptoms as fever and leukocytosis. The localized symptoms include soreness, pain, muscle guarding on palpation, and restriction of movement. The site of the localized symptoms depends on the segment of the colon that is involved. Since diverticulitis most commonly occurs in the sigmoid, the most common site of the localized manifestations is the left lower quadrant of the abdomen.

Repeated attacks of diverticulitis cause strituring and obstruction of the intestine. Free perforation of a diverticulum of the colon rarely occurs into the peritoneal cavity. However, chronic perforation which progresses slowly enough for the reparative reaction to keep the infectious material confined and thus form an abscess occurs commonly in cases of diverticulitis. Spontaneous or surgical evacuation of the abscess is followed by the formation of a fistula which may communicate with segments of the intestine, with the urinary bladder or with the skin. The cutaneous fistulas usually are situated in the perineal or perianal region.

A **Meckel's diverticulum** may become infected, and the resulting diverticulitis may cause fever and pain. Clinically, this condition is difficult to distinguish from appendicitis. Hemorrhage is a common manifestation of infection of a Meckel's diverticulum. The hemorrhage usually is not accompanied by pain.

Ectopic Tissue.—Vestiges of embryonic structures may persist as bands or pouches.

Kinks and Bands.—Congenital kinks, such as Lane's kink, are not of common occurrence, and they do not cause any symptoms. Mesenteric bands, which served as anchors for the intestine during embryonic development, while the intestine was contained in an umbilical hernia, may persist in the duodenum, jejunum and the middle portion of the transverse colon, which prenatally were the terminal portions of the midgut.

Infection and Infestation.—Patients often date the onset of an abdominal disorder from the advent of an infection. Staphylococci cause a well-defined syndrome of food poisoning. In this type of infection, violent vomiting, diarrhea, fever and great weakness occur 4 to 6 hours after the ingestion of egg salads, custards or dairy products. These symptoms subside in 24 to 48 hours, and recovery occurs without any sequelae.

In cases of proctitis, it may be difficult to identify certain bacteria such as streptococci, Clostridium perfringens and Neisseria gonorrhoeae as the causative agents. At times, these microorganisms may cause chronic diarrhea. Bacillary dysentery is an acute infectious disease of the intestine which rarely lasts long enough to cause chronic diarrhea of several months' duration.

Salmonella typhosa is the etiologic agent of typhoid fever. In cases of this disease, healing occurs without chronic sequelae. Salmonella paratyphi produces two different syndromes. One is very much like typhoid fever; the other is an acute

type of food poisoning which resembles that caused by staphylococci.

Tuberculosis of the intestine occurs in two different forms: (1) intestinal tuberculosis which is associated with pulmonary tuberculosis, and (2) so-called hyperplastic tuberculosis which is situated in the ileocolic segment. The latter is a chronic disorder which may be difficult to diagnose without the assistance of an experienced roentgenologist. The symptoms include abdominal pain, diarrhea and fever, and palpation often reveals a mass in the right side of the abdomen.

Infection with the virus of lymphopathia venereum often produces a stricture of the rectum. If the stricture becomes ulcerated in the acute stage of the infection or subsequently, it may cause frequent emptying of the bowel.

Patients often date the onset of many and diverse intestinal disorders to a virus infection or influenza. Viral infections of the intestine seem to be acute disorders without sequelae. The herpes group of viruses can cause mucosal eruptions and dysenteric disorders, but these also are acute and of short duration, and heal completely.

Reimann and associates have called attention to a mild form of epidemic diarrhea which is probably caused by a filtrable virus. This viral diarrhea seems to reach epidemic proportions in very much the same way as do bad colds. Reimann transmitted the filtrable agent of the disease to volunteers by means of nasal sprays containing infected material obtained from patients who had the disease. Chronic diarrhea is not a sequela of this disorder.

A chronic septicemia, such as subacute bacterial endocarditis, is often attended by abdominal cramps and diarrhea.

Syphilitic infection of the intestine is difficult to define and certainly a chronic diarrhea cannot be attributed to syphilis.

Intestinal actinomycosis may cause chronic diarrhea which resembles that of tuberculosis. Intestinal nocardiosis is less common. The fungi imperfecti, including Candida albicans, rarely cause disease. Candida albicans is found in large numbers in the stools of patients who have chronic diarrhea due to such causes as sprue and pernicious anemia. It would be difficult to prove that fungi imperfecti cause chronic diarrhea.

Histoplasma capsulatum may infect the intestine and cause a chronic diarrhea resembling that observed in cases of intestinal tuberculosis or actinomycotic infection.

The protozoan parasites, Endamoeba coli, and the flagellates, Giardia lamblia, Trichomonas hominis and Chilomastix mesnili, may be associated with chronic diarrhea. However, it is not diagnostically safe to assign the diarrhea to any of these organisms. The infusorian, Balantidium coli, causes a serious acute colitis when the bowel becomes obstructed. It is not a cause of chronic diarrhea.

Endamoeba histolytica causes acute and chronic disorders of the colon characterized by the presence of bloody stools. The condition is distinguished by the presence of Endamoeba histolytica in the feces.

The helminths, aside from Ancylostoma duodenale (hookworm), do not cause any definite intestinal disorders. Hookworm infection retards development of children and renders them anemic, pot-bellied and stupid. The tapeworms usually do not cause any symptoms before the patient knows of the infestation.

The Allergic State.—Allergy and the allergic reaction or allergic digestive symptoms may occur in any person who has been endowed through heredity with the allergic state. In such a person the oral ingestion of specific antigens or antigenic substances may induce allergic symptoms. These symptoms are the manifestations of intestinal hyperemia, edema and increased mucous secretion occurring during the allergic reactions. Since allergic reactions may be localized or generalized in the alimentary tube, the symptoms may be localized or generalized digestive dysfunctions.

The localized symptoms of digestive allergies perhaps occur more frequently in the colon than elsewhere in the alimentary tract. An allergy may contribute to or entirely account for the so-called irritable colon syndrome in an insignificant number of cases of this disorder. Colonic dysfunction of allergic origin is more often expressed as repetitious attacks of diarrhea and abdominal pain than as severe episodes of abdominal pain associated with vomiting and diarrhea and accompanied by systemic symptoms and signs of shock.

In order to attribute gastrointestinal symptoms to allergy, the first diagnostic requirement is the presence of the allergic state. There should be a genealogic history of allergy, and a history of definite reactions to the eating of certain foods, drinking of a particular beverage or taking certain drugs, or a reactivity to specific extraneous substances. In the absence of known reactions to such substances, the presence of hay fever or asthma is confirmatory evidence of the presence of the allergic state. In all instances of intestinal disorder, there should be a periodicity of the

symptoms like that present in cases of hay fever and asthma. The attacks of abdominal pain or diarrhea should be partially or totally relieved by the administration of epinephrine. The presence of an eosinophilia during the attack is important diagnostically.

The ability to relieve abdominal pain, diarrhea, and mucous discharge by discontinuing the use of foods to which patients seem to be sensitive and the subsequent reappearance of symptoms following the ingestion of those foods are diagnostically helpful, but time and repetition of this sort of diagnostic procedure are necessary before a definite diagnosis of an intestinal allergy can be made. A psychic colonic disorder will often respond well to the avoidance of certain foods for short intervals. A diet of lamb chops and rice benefits the patient who has an allergic intestinal disorder, and it will please the patient who has an intestinal psychoneurosis.

Hormonal Disorders.—The health and the physical attractiveness of a person are largely dependent on intrinsic or glandular hormones and extrinsic or plant hormones (the vitamins). An excessive amount of thyroid secretion may be accompanied by abdominal discomfort and diarrhea. A deficiency of the thyroid secretion renders the intestine sluggish, and constipation ensues. A deficiency of the exocrine secretion of the pancreas causes bulky, light-colored, greasy stools which float on water. A deficiency of the cortical secretion of the suprarenal glands results in Addison's disease which may be manifested by abdominal cramps and irregular evacuation of the intestinal contents.

The vitamins are extrinsic hormones which occur in plant and animal foods. The best known vitamin deficiency diseases are scurvy, pellagra and pernicious anemia. There are probably additional vitamin deficiencies characterized by the presence of macrocytic anemia, such as tropical sprue and tropical macrocytic anemia. These deficiencies are attended by aberrations of intestinal function.

Diseases of Unknown Origin.—The organic diseases of unknown origin which may be difficult to distinguish from functional disorders may be divided into two large groups. The first group is composed of those disorders due to or consisting of static mechanical abnormality; for example, intestinal obstruction due to herniation into omental sacs or fossae, and low-grade intestinal obstruction perhaps occurring intermittently. The unknown component is why should these disorders develop in some cases but not in others. Omental sacs and fossae are present in every person. Such conditions cannot be diagnosed by any means other than direct inspection and palpation after the abdomen has been opened by a surgical procedure. The history often is identical with that of a functional disorder.

In the second group, the origin is truly unknown. The disorders in this group are due to unknown causes and a structural reaction alone is manifest. Examples of these are regional ileitis and chronic ulcerative colitis. Idiopathic ileitis and idiopathic chronic ulcerative colitis in their fulminating forms can hardly be diagnostically confused with any other diseases. However, mild forms of a chronic idiopathic ileitis may be manifested by general or constitutional symptoms consisting of loss of body weight, fever and anemia without distinguishable features on either physical or roentgenologic examination. Atypically, chronic ulcerative colitis may be attended by constipation, particularly in the aged patient. Idiopathic chronic ulcerative colitis proximal to the part of the colon which can be viewed by the endoscope may be difficult to diagnose. In due time, however, an ileitis or a colitis will become fully manifested, and endoscopic and roentgenologic examination are the bases for a definite diagnosis.

Neoplasms.—The neoplasms of the intestines comprise both benign and malignant tumors. The benign tumors include adenomatous polyps, lipomas, cysts, leiomyomas and leiomyofibromas. Leukoplakia may occur in the rectum, and endometriosis may affect the distal portions of the colon and rectum. The benign tumors are generally adenomatous polyps. These may occur singly or they may be disseminated throughout the colon. Benign tumors of the small intestine are rare. There is a form of disseminated adenomatous polyps of the colon and, occasionally, also of the small intestine which is of congenital origin.

Malignant tumors of the intestine are usually carcinomas. However, sarcomas, often of the Hodgkin's type, may occur as polyps in the colon or rectum.

Generally, benign and malignant tumors of the intestines occur in the colon of aged persons. Their manifestations are essentially the same, and consist of hemorrhage, degrees of intestinal obstruction, anemia, and loss of body weight.

The neoplasms of the intestine are the most important group of organic disease which must be distinguished from functional disorders.

Functional Disorders of the Intestine

A functional disorder of the intestine is a physiologic disturbance not due to any known primary

structural change. There is no general agreement on this concept, however, since the scope and limitations of functional disturbances cannot be defined and, more particularly, since a clinical distinction between what is functional and what is structural often cannot be made.

Each functional disorder of the intestine has to be distinguished from organic disease of the intestine. It, therefore, is necessary for the diagnostician to have in mind systematized data on the cause and manifestations of these disorders. These data are comprised of information concerning the influences on the intestine which may arise in response to heredity and psychic tension. In a certain case it may be difficult to determine whether the prevailing cause of the disturbance is a response to heredity or a response to psychic tension.

A hereditary tendency toward functional intestinal disorders may be of significance in some families. A full genealogic history may reveal a high incidence of intestinal dysfunction in members of the preceding generations.

The assumption has been made that imbalance of the autonomic nervous system may be inherited. The nerve imbalance is termed "vagotonia" or "sympathicotonia." Persons who inherit these types of imbalance are termed "vagotonics" or "sympathicotonics," depending on whether the parasympathetic or the sympathetic nervous actions prevail. Vagotonic persons have short necks, wide chests, and are stout, whereas the sympathicotonics have long necks, narrow chests, and are slim. Such oversimplicity in the recognition of functional disorders of the intestines in accordance with body type has not proved to be of value in either diagnosis or treatment of disorders of the intestine.

The intrinsic nerves of the intestine include the myenteric plexuses of Auerbach and the submucous plexus of Meissner, which are influenced by the two major divisions of the autonomic nervous system. For instance, hypertonicity and increased peristalsis and spasticity of the sphincters follow increased vagal activity, whereas dilatation and sluggishness of the intestine follow increased sympathetic activity.

Pain may originate in the gastrointestinal tract as a result of either overdilatation or overcontraction of hollow viscera, and from stretching of the capsules of the solid organs as the result of imbalance of the autonomic nervous system.

The digestive disorders caused by psychic tension, which may be a part of the personality or result from emotional conflicts or anxiety, have their principal relay station in the diencephalon. The diencephalon exerts a regulating influence on both of the major divisions of the autonomic nervous system which also centers in it. The diencephalon has a direct influence on most of the endocrine glands, on metabolism, and on all hemostatic processes. It receives impulses from and sends impulses to the cerebral cortex. Therefore, in states of emotional conflict and abnormal tension, the diencephalon may be influenced from the cerebral cortex and then set up impulses responsible for secondary changes in function of the viscera.

In cases of functional intestinal disturbances there may be a change of affect, and this is termed the "subjective phase." There are often disturbances of the special senses such as sensations of appetite, hunger and pain. The objective phase, due to psychologic disorders of digestion, includes disturbances in the neuromuscular, autonomovisceral and secretory functions. These disturbances are termed "objective" because they can be observed clinically.

Psychic tension may be related to changes in the affect, and thus may be attributable in part to the personality of the patient. In order to identify these disorders of the affect or those of personality which may cause disturbances of intestinal function, and to treat them satisfactorily, the physician should have a basic concept of the structure of personality, type of personality, and the various types of reaction in relation to disease processes.

Personality development begins with the inborn instinctive tendencies. These instinctive tendencies may be repressed, suppressed and modified in many ways. Despite modification, they remain a strong positive force in the development of the personality types. The amalgamation and supporting energy of the instinctual drives are the emotions. During the course of development there is always some conflict between these inborn instinctual tendencies and the social, moral and religious demands of an organized society. The adjustment to the conflicts incident to these demands determines the impulse, temperament and character of the person and his modes of thinking, feeling and acting—all of which constitute personality.

The types of personality reactions include: (1) the organic reaction, (2) the affective reaction, (3) the schizophrenic, and (4) the psychoneurotic. The organic reaction occurs in association with structural diseases of the brain due to vascular and degenerative changes, neoplasms, infection,

intoxication and deficiency states. This reaction is predominated by intellectual disturbances. The affective reaction occurs in the presence of hypomania and involutional melancholia. The schizophrenic reaction, which consists of many bizarre modes of thinking, feeling and acting, is observed in schizophrenia. The most important reaction seen daily in the practice of medicine is the psychoneurotic, and from here on this discussion will be directed mainly toward this reaction.

A state of psychic tension often antedates the onset of functional digestive symptoms. The significance of neurogenic factors in the initiation of symptoms is stressed by the relief which is often afforded by a change of environment, a vacation, a brief period of isolation in a hospital away from the worries of business and home, and the temporary relief which may follow the drinking of alcoholic beverages.

A state of anxiety with the resulting manifestations is termed the "anxiety syndrome," which is expressed by palpitation of the heart, rapid and shallow inspiration, sweating, pallor and a feeling of panic. This syndrome follows prolonged psychic tension. The anxiety state may be defined as an emotional disturbance. Anxiety alone gives rise to hostility which, in turn, generates more anxiety. Indeed, certain patients seem to have the ability to create anxiety in the family and finally in the physician. Once this has been done, neither the physician nor the patient may realize that hostility toward each other is the prevailing mode. The existence of both anxiety and hostility helps to explain the reasons why the neurotic patient is driven imperatively toward dominating everyone, toward complying with others but at the same time imposing his will on them, toward detachment from people but at the same time toward a craving for their affection. These conflicts may be the dynamic center of the neuroses and the physician-patient relationship.

Motor disturbances of the intestine resulting from psychic tension may be the cause of an irritable colon syndrome. In the irritable colon syndrome the small intestine also may be hyperirritable. When the small intestine is affected, the roentgenologist may report that the barium meal arrives in the colon in from a half-hour to 4 hours after its ingestion. It seems that the main seat of the dysfunction in many instances is in the small intestine.

Psychic tension sufficient to cause the symptoms are the commonplace events of life such as (1) sickness, accidents and deaths in the family, (2) loss of property, job or money, (3) inability to attain social prestige, (4) betrayals by business associates, members of the family or friends, and (5) erroneous moral and physiologic interpretations.

The symptoms often continue long after the exciting cause ceases to operate, and thus represent release phenomena of the neurotic traits of the previously apparently well-integrated personality.

The Irritable Colon Syndrome.—The terms "irritable colon" and "unstable colon" are used to embrace all of the manifestations of the colonic neuroses. The disturbances of the motor activity of the colon are the commonest. These disturbances are manifested by constipation or by diarrhea. The mixed neuroses are the next in frequency of occurrence. These are characterized by alternating constipation and diarrhea, and frequently are attended by abdominal discomfort or pain. Disturbances of the secretory functions of the bowel, characterized by the passage of excess mucus, may be associated with either constipation or diarrhea. Not infrequently, normal bowel habits may be present for long periods between attacks of colonic dysfunction. The shape of the formed stools is frequently displeasing to the patient who has an irritable colon. The passage of small, hard pellets or scybala may precede or follow an episode of abdominal discomfort. The patients may have neither constipation nor diarrhea.

In the medical literature statements will be found that the irritable colon syndrome, including both diarrhea and constipation, is due to the tension of present-day civilization. There are no data to prove that psychic diarrhea and constipation are any more prevalent in modern civilized men and women than they were or are in savages. During the seasons of fresh berries and other fruits, most savages have diarrhea. When food supplies are scarce, the savages probably are constipated. So far as psychic tension is concerned, the savage, racked by fear of his enemies, torn between the exigencies of strife for his personal existence and the signs and implications of the presence of demons, spirits and gods ready to bring disaster on him, had and has more to be tense about than have the present-day civilized men and women.

Constipation.—Constipation may be defined as an abnormal retention of fecal matter in the intestinal canal or an undue delay in the discharge of excreta from the rectum. Constipation may be a manifestation of the irritable colon syndrome. In this syndrome, there may be alternating constipation and diarrhea. However, there are a

great number of stable and stoic persons who are constipated from causes not necessarily a part of the cause of this syndrome.

The cause of constipation are: 1. The passage of the food residue and excreta along the colon is abnormally slow. 2. The food residue reaches the rectum without delay, but defecation is inefficient or difficult. The natural posture for defecation is the squatting position, with the thighs flexed upon the abdomen. In this posture, the capacity of the abdominal cavity is reduced and intra-abdominal pressure is increased, thus aiding the expulsion of the fecal mass. The modern toilet seat in many instances is too high. Unless the toilet seat is low enough that the feet may rest firmly on the floor and some flexion of the thighs is possible, the accessory muscles which aid in defecation normally have little opportunity to fulfill their function. Four muscular structures responsible for the expulsion of the fecal mass are the muscles of the abdominal wall, the diaphragm, the levator ani muscles and the smooth muscle of the intestinal wall. These should be aided by posture during the act of defecation.

If the upright position of man, as has been claimed, causes constipation, it is because there is an increase in the distance that the intestine must raise the intestinal chyme against gravity. Measurements of this distance are comparable in man and the quadrupeds. Likewise, it is erroneous to assume that there is lack of support of the intestine of man while he is in the upright position. The ruminant quadrupeds have relatively a much longer alimentary tract; they eat a much greater quantity of food; carry it for longer periods, and have no more support of the intestines than does man.

The size of the colon of man is midway between that of the colon of herbivora and the carnivora. The herbivora are not constipated. The carnivora may be constipated. Man, possessing an alimentary volume midway between that of these two animals, and eating a sufficient amount of food for maintenance, invalidates a general statement concerning the influence of dietary factors on the development of constipation.

The important cause of constipation is improper training and neglect in very early childhood. When a child is trained to have bowel movements at a specified time or, better still, if left alone, there will be no constipation. In later life, if a person does not have time for bowel movements and to allow the bowels to act normally, the physician cannot be of any help.

The lack of adequate facilities may be given as the reason for the frequent neglect to move the bowels after fecal matter has entered the rectum and initiated the desire to defecate. Usually, this sensation soon passes off although the fecal matter remains in the rectum. It is not until a fresh increment of feces further distends the rectum that the desire to defecate recurs. After a time, because of the constant residence of feces in the rectum, the defecation sense may be blunted and finally may disappear entirely. If toilets are not available, patients may be advised to provide themselves with suitable vessels which can be emptied later.

In the minds of many people there is the idea that a weekly cleaning out by a strong purgative is beneficial to the body economy. This practice goes back many centuries and will continue for many more centuries. Its detrimental effects have not been proved. It may destroy normal bowel habit.

Constipation occurs in persons of all ages who do not or are not allowed to leave the act of defecation to normal control. Constipation produces no other subjective symptom or objective evidence of disease. In cases of simple constipation, symptoms are rare unless the patients are hypersensitive. Constipation as a symtom of organic disease or of fecal impaction is accompanied by various discomforts depending on the nature of the disease or the cause of the impaction.

Diarrhea.—Diarrhea is an abnormal frequency and fluidity of fecal discharges. The number of bowel movements within a period of 24 hours which may be considered to be within normal limits varies from one to three in most persons. However, a person who normally has one bowel movement during a 48-hour period and then suddenly commences to have three bowel movements within 24 hours would certainly be considered to have a diarrhea. It, therefore, is evident that what constitutes a diarrhea for a particular patient depends on the bowel habits which he considers to be normal during health.

Both acute and chronic diarrhea may be caused by psychic influences. In addition to the diarrhea, the psychic disturbances may be manifested by anxiety, failure to relax, and fatigue.

The history will often separate a chronic diarrhea due to organic disease from one due to psychic factors. In a case of organic disease the symptoms will have a definite onset. Often, fever, bloody dysenteric stools, loss of weight, and symptoms which disturb sleep are, or have

been, present. The history in a case of diarrhea of psychogenic origin will reveal a constancy of symptoms which commenced with the inception of anxiety. There will not be any disturbance of sleep from the diarrhea or loss of weight without the presence of sitophobia. Rectal bleeding will be absent unless an anal fissure or hemorrhoids are present.

The patient who has psychogenic diarrhea will often complain first of a sense of indescribable danger and impending illness, and of irritability, insomnia, anorexia, confusion and slowed thinking. Difficulty in breathing, palpitation, vertigo, weakness, increased sweating, dysmenorrhea and headache may be present.

Mucous Colitis.—Mucous colitis is the clinical manifestation of a functional colonic derangement characterized by the discharge of excessive quantities of mucus in the stools in the absence of demonstrable colonic disease.

A common cause of loose bowels is the self-prescription and administration of aperients and bulk-forming cathartics. It is well to inquire in regard to prescribed drugs or self- administered drugs when the history is being taken in a case of chronic diarrhea.

Many drugs used as vehicles and placebos may be the source of ill-defined intestinal disorders simulating an irritable colon syndrome. These drugs may be pharmacologically classified as follows: (1) bitters which include gentian, quassin and calamus, (2) digestants which include mineral acids, pepsin, pancreatin, bile salts, and vegetable ferments, (3) carminatives which are composed of volatile oils, (4) absorptives such as charcoal, kaolin and pectin, (5) antacids such as sodium bicarbonate, aluminum hydroxide, aluminum oxychloride and mucin, (6) aperients, for instance, castor oil and mineral oils, sulfur, glycerin, calomel, agar, psyllium, gum karaya, anthracine, phenolphthalein, jalap and colocynth, and (7) saline preparations, all of which exert a laxative effect.

Carbohydrate foods in excessive quantity, such as may be obtained from a meal of pancakes and honey, often cause intestinal disturbances, gas, cramps, and explosive bowel action.

There are many substances which are toxic to everybody, while there are others which depend on a special host susceptibility before they can be considered to be toxic. It, therefore, may be difficult to detect and determine the toxicity of certain foods and drinks.

Excessive amounts of fat in the diet may cause nausea and vomiting. They seem to slow peristalsis in the proximal portions of the alimentary canal. However, excessive amounts of fats or partially saponified fats (soaps) present in the distal segments of the small intestine or proximal part of the colon may be the cause of excessive amounts of feces passed at frequent intervals. Feces of a high fat content float on water and have a greasy appearance. These changes in the feces also occur in nontropical sprue and in Whipple's disease.

Achlorhydria once was thought to occupy a prominent place in the production of chronic diarrhea. At times, and under conditions which cannot be determined, achlorhydria may cause loose bowel movements. However, an irritable colon syndrome generally does not originate from achlorhydria.

Comment

The patient who has an organic disease of the intestine may have either diarrhea or constipation with or without the passage of blood, mucus, excessive fat or flatus. Pain may be present, and it may be associated with physiologic activity of the intestines, for instance, defecation and, in some instances, peristaltic activity. There may be fever and loss of body weight. In the presence of infection by the pyogenic organisms, there may be a leukocytosis. In the case of long-standing infection or an advanced malignant lesion, anemia usually is present. The degree of tenderness of the abdomen, the presence of distention, ascites, and excessive peristalsis, and whether or not a tumor is palpable depend on the nature and stage of the disease present.

In some instances of organic disease of the intestines, the diagnosis depends on the presence of pathogenic bacteria, viruses, parasites, noxious chemicals, or other materials in the blood or excreta.

The patient who has a functional disorder of the intestine has symptoms which may be present in any known disease of the digestive system. However, these symptoms are not associated with fever, leukocytosis, guarding of the abdominal muscles or a palpable tumor. The symptoms and the history often reveal the presence of an anxiety state or the symptoms may be reactions of an anxiety state which has changed to a compulsive-obsessive or neurasthenic state. Such symptoms vary from mild headache, fatigue and irritability to intractable insomnia with marked agitation and rapid loss of body weight.

Persons who possess an appropriate temperament may be able to make their physical symptoms overshadow completely their primary psychisms. When the physical symptoms over-

shadow the primary psychisms, the patient may be advised to undergo an exploratory laparotomy. One of every 4 patients who has an irritable colon syndrome has had his appendix removed.

In cases of functional disorders general examination does not disclose any evidence of loss of body weight unless anorexia or sitophobia, functional vomiting, or diarrhea are present. There are often found (1) cold, moist hands and feet, (2) dry mouth and lips, (3) a variable pulse rate, (4) a variable blood pressure, (5) tenseness, (6) tenderness of the abdomen without muscle guarding and (7) hyperactive tendon reflexes.

In the presence of intestinal disorders associated with diarrhea, the following examinations should be performed in the order given: (1) the feces should be examined for ova and parasites (three examinations, on successive days, of liquid stools obtained by the administration of 1 ounce of magnesium sulfate to the fasting patient); (2) proctosigmoidoscopic examination; (3) roentgenologic examinations of the stomach, colon, and also, occasionally, the small intestine; (4) examination of the gastric contents (presence of hydrochloric acid); (5) determination of the basal metabolic rate if the presence of hyperthyroidism is suspected, and (6) examination of the blood and urine for evidences of poisoning by certain chemicals and for the presence or absence of leukocytosis and anemia.

In the presence of intestinal disorders manifested only by constipation, in addition to the general physical examination, endoscopic and roentgenologic examination of the colon should be performed and the blood should be examined for evidence of leukocytosis and anemia. It may be necessary to determine the basal metabolic rate when the presence of hypothyroidism is suspected. In some cases, the blood and urine are examined to detect the possible presence of a heavy metal, such as lead.

When organic and functional intestinal disease coexist, evaluation of the degree of each is required. The evaluation of the etiologic relationship between these syndromes is often difficult even after extensive investigation. The presence of an organic lesion may not be discovered. Likewise, it may be impossible to find an adequate psychogenic cause for a functional disorder.

In many instances, a period of observation and repeated examinations are required before organic and functional disorders of the intestine can be differentiated.

REFERENCE

Reimann, H. A., Hodges, J. H. and Price, A. H.: Epidemic Diarrhea, Nausea and Vomiting of Unknown Cause. J.A.M.A. 127:1-5 (Jan. 6) 1945.

GENERAL PRACTICE IN RURAL MEXICO*

By JAMES HERVEY ROSS
Morelia, Michoacan, Mexico

The Republic of Mexico, with its twenty million inhabitants very largely scattered over sparsely settled rural areas, offers a challenge to the practicing physician to bring the advantages of modern medicine to its neglected millions.

The country as a whole has only about six cities worthy of the name, where the best medical practices of the world can be found: **Mexico City,** of over two million inhabitants; **Monterrey,** the industrial capital of Mexico in the north; **Guadalajara,** second largest city, in the west coast state of Jalisco; the port cities of **Vera Cruz** and **Tampico,** on the Gulf of Mexico; and **Merida,** on the peninsula of Yucatan.

Beyond these are a host of minor cities, towns and villages, loosely connected by farms and ranches, in a gradually descending scale of wealth, culture and medical advantages. It is here where medicine is ten, twenty, even fifty years behind the times; here where great responsibility and opportunity lie.

Along about halfway in this scale we find the city of Morelia, of some 60,000 inhabitants, capital of the State of Michoacan, and lying some 6,000 feet above sea-level in the heart of the Sierra Madre mountains. It is here that thirty-five years ago the Sanatario "La Luz," a Presbyterian mission hospital, was founded by Dr. L. J. Coppedge, former medical missionary to the Belgian Congo. Dr. Coppedge chose for the site of the new hospital a building which was constructed around 1775—hardly the latest in hospital building!

The first thing he did was to screen in the immense inner courtyard against mosquitoes and flies—positively the most ambitious screening job

* Read before the Seventy-eighth Annual Session, Arkansas Medical Society, Fort Smith, April 19, 1954.

I ever saw. He began with a modest fifteen beds, and against stiff opposition from local doctors and the general ignorance of the people began building up a practice, largely among the poorer country people who came in from as many as thirty to forty miles away for medical treatment, surgery, teeth pulling, and general comforting.

One of his early experiences taught him to go slowly in trying to introduce new methods of sanitation to country people "sot in their ways" and steeped in the superstitions of their herb medicine men. He had issued orders that all patients admitted to the wards were to receive an admission bath. An old gentleman, more for the other world than this, was given the routine bath, over the loud protests and dire predictions of his relatives—patients usually being accompanied by veritable tribes of family connections. Soon he passed on, and his demise was blamed directly on the bath. After that, all patients were offered admission ablutions, but none was forced to take what might be considered a sure ticket to the great beyond.

In the early days many of these people suffered first and foremost with **malaria,** so that they often came in with a broken leg—and malaria, to have a baby—and malaria, operations—and malaria, everything—and malaria.

Fortunately, this picture has changed, and while we still see some malaria, the Health Department's efforts along the lines of swamp drainage, and public education through campaigns and charts, have largely eliminated this disease in our section of Mexico.

Another very positive victory for the Public Health Department has been the eradication of smallpox, for while there are always a few cases scattered hither and yon the smallpox epidemics of my childhood in Mexico are a thing of the past. I can recall, as a boy of six, an outbreak in the small town of Linares, Nuevo Leon, where we lived. We, the missionaries' children, were taken into Monterrey where we were vaccinated and then taken back to Linares. When the pustule formed, arm to arm vaccination was carried out to protect the remaining children of the village. Now, "Salubridad" (that is, the Health Department) has adequate amounts of smallpox vaccine and all children are inoculated during their first year in school.

A problem early met, and perforce requiring immediate solution, was the preparation of well trained Mexican nurses to help carry on the work. This led to the establishment of a school of nursing, the girls coming from the poor but ambitious families of the rural areas.

The school, which began with a mere handful of girls, has now grown to a fully accredited, three-year school of nursing, with an enrollment of over sixty girls, and affiliated with the National University of Mexico, now rounding out its fourth century of continuous existence.

In the early days the girls were admitted with a grammar school certificate. At present we require them to have a high school diploma—no mean accomplishment in itself in this part of the world.

There are now about twenty accredited schools of nursing over the country as a whole.

Our patients come to us overland, walking, riding donkeys and horses, being carried on home-made stretchers of poles and straw mats, and lately in buses, taxis, trains, and even planes.

But not all the flow is concentric—we do some of the going out. On these field trips we make up teams of doctors, nurses, and social workers and invade some out-of-the-way villages. Here we set up improvised clinics, give health lectures, and start dispensing shots, pills, and offering to lance abscesses or pull teeth. This latter usually proves quite a drawing card.

I especially recall one such trip we made. We set up our clinic in a small adobe house which possessed only one small door and an even smaller window. The usual crowds gathered, the better to listen to one another's symptoms and observe the skill of the doctor. Privacy is practically non-existent in such country clinics.

We began pulling teeth and, since not everyone could crowd into the small room to see, a goodly number were scattered up and down the street. A tallish young man with a sense of humor leaned into the window, obscuring our one source of light, and gave a "cuspid, bicuspid" account of the extractions to the ones in the street, much as a sportscaster might announce a boxing match or a football game over the radio. He would say, "Now the mouth is open—now he has the tooth—now it is out!"

One of the foremost medical problems facing Mexico today is the extremely high infant mortality rate. Exactly what it is no one knows, but estimates, based on a few known facts and a lot of good guesses, place it as close to four out of ten children who die before the first year of life is out. Malnutrition, severe vomiting and diarrhea are probably the principal causes, these in turn largely due to faulty feeding habits, though whooping cough and complications following measles take a high toll. The most encouraging step which has been taken towards combatting this

situation has been the establishment of the magnificent 900-bed Children's Hospital in Mexico City where since 1945 successive generations of pediatricians have been trained and sent out to spread the good work over the country as a whole. We have one such man on our staff, and the simple introduction of intravenous fluids and the judicious use of antibiotics by him has saved the lives of hundreds of infants.

With the beginning of every rainy season—lasting from June to September—comes the avalanche of typhoid fever cases. Before the advent of chloromycetin we would sweat these cases out for thirty or forty days and then sit in dread of a relapse. However, since cloramfenicol, which is definitely the drug of choice, the story has changed, and on the fourth or fifth day the fever drops to normal where it usually stays.

Tuberculosis, syphilis, gonorrhea and intestinal parasites we meet daily. Poliomyelitis is a rare disease among Mexicans—that, or we have the mild, non-paralytic forms among the younger children which go unrecognized, leaving the older children immune. We see our full share of gunshot wounds and stabbings, most plentiful around national holidays and religious festivals when the citizenry get rip-roaring drunk in patriotic fervor over some obscure battle of the War of Independence or in sacred memory of one of the several hundred saints listed on the calendar.

Not lacking, either, of course, are complications arising from the eternal triangle. One gentleman we treated sported thirteen stab wounds as proof of his loyalty to his lady-love—or maybe he was poaching on another man's rights, I forget which. One proof that we are becoming civilized is that more and more of our injury cases are due to accidents involving that modern machine of destruction, the automobile. The treatment of fractures has become my "specialty," if I might be permitted to use the term loosely, and I have found the use of the Stader Splint, intramedullary pinning, especially in fractures of the femur, the Smith Petersen nail and our old friend the plaster cast, of great help.

One of the best reduced fractures of the tibia I ever saw was performed by a Tarascan Indian bone doctor on another Indian. My Indian colleague had used corn stalks interlaced with string and hardened in resin as a cast. X-ray showed the reduction to be as good as could be desired. However, the Indian tribe accompanying the patient would not hear to my leaving things as they stood, but insisted upon my removing resin, strings, and corn stalks—a messy job, to be sure—and placing a bona fide plaster cast in its place. "Otherwise," said they, "why go to all this trouble of bringing him twenty-five miles to a hospital?"

The problem of treating the poor in a country with a low standard of living is obviously enormous, hence our ridiculously low fees. A ward-bed in our mission hospital costs a patient six pesos a day—about seventy-five American cents at the current rate of exchange. Even so, many cannot even pay these rates.

I recall an old woman who brought her grandchild to us for examination. We found she needed a tonsillectomy, and when the matter of price came up the old lady said, "I have no money to pay for operations, doctor." When told she could pay whatever she felt she could afford, she offered twenty pesos (about two and a half dollars), and we agreed to operate. On the appointed day the child was hospitalized and brought to surgery. Under ether anesthesia we had already removed the first tonsil and were about to proceed to the second when, much to our consternation, we spotted and promptly proceeded to extract from her pharynx **a green marble.** How it got there or what it was doing in the middle of our operation we did not know. Greatly puzzled, we removed the other tonsil, a few shreds of adenoid tissue, and, in passing, three badly decayed teeth. Post-operative exhibit: two red tonsils, some pinkish-grey adenoids, three yellowed teeth, and **one green marble.**

Later, when the child was quizzed about the marble, she confessed to having kept it under her tongue. "I often stick a marble in my mouth," she said. "It's a kind of game with me—my hungry game, for the mornings when I got little or no breakfast."

About two years ago we began construction on a modern, 100-bed hospital which we occupied last September with due pomp and ceremony, abandoning our 200-year-old building with few tears and no regrets. While still lacking many things, we are nonetheless infinitely better equipped, have more light and ventilation, and at least look like a hospital.

In a symbolic way, I believe our own change for the better, small in its way, is indicative of changes in medicine for the better which are taking place all over Mexico, and that the future of medicine in Mexico, especially in the rural areas, will witness greater advances in the coming decade than it has in the last half-century.

THE CHALLENGE OF GENERAL PRACTICE*

C. R. ELLIS, Malvern
President Arkansas Academy of General Practice

I. Introduction

Some of these challenges may seem trite to you who have spent four years in our medical school and reached your graduation day. You may say "I have heard that before. I have already passed that milestone,"; but as a young physician who thought the same thing, may I say that you will appreciate many of the so-called unnecessary points of your teaching more and more as the years pass.

I recall just now a statement made by Dr. Langston to our freshman class. "Gentlemen and Ladies, you will be studying and learning more about medicine the rest of your life. You will never finish studying." My first reaction was "Dr., you may study like this all of your life; but, if I ever finish four years here, I'm going to stop this grind." It is needless to state that I had changed my thinking even before my senior year. And I appreciate the significance of Dr. Langston's statement more each passing year.

What is a Challenge? The dictionary defines it as: an invitation to a conflict; a summons to fight; a duel. Even though we may never meet and conquer our problems, the invitation to the conflict still remains and the fight for life, health, and happiness continues.

II. The Challenges

First, the general practice of medicine and surgery challenges us to know the anatomy, physiology, and pathology concerning all the organs and systems of the body. As general practitioners, we cannot confine our knowledge to any one body section, system, or organ. We may be confronted with a severe brain injury, a coronary thrombosis, a fractured femur, an acute appendicitis, and a severe post-partum hemorrhage within the same hour. Our nearest consultant in any of these specialties may be fifty miles away. We must often make decisions and institute definitive treatment rapidly. There are certainly moments when each of us asks himself: "Just where is that nerve in relation to the bone at this fracture site," or "Just what was it Boyd says happens the first few hours after a thrombosis?" Yes, we can go read again if time permits; but that prevents our fullest usefulness in our practice. We will, no doubt, have to review our studies often. You will, too. But the challenge still remains—To know the anatomy, physiology, and pathology concerning all the organs and systems of the body.

Secondly, general practice challenges us to treat the entire patient and to do our histories and physical examinations to that end. When we find no objective signs of pathology in a painful throat, we, as family physicians, cannot simply say, "I find no disease of the throat." We must find the cause of the pain. The patient came for that purpose. The real disease may be in his chest, blood stream, glandular system, nervous system, or some other area. And, please believe me, doctors, this type challenge is sometimes almost insurmountable. We must remember, however, that our patient is an entire individual—not just a painful throat.

Thirdly, general practice challenges us to be ethical in our relationship with our fellow physicians, both general practitioners and specialists. To do this, we must first know the principles of medical ethics and understand that they are to be observed primarily for the best interest of our patients, not primarily for our interest. "There is no limit to the good a man can do if he does not care who gets the credit,"—a statement from a recent magazine — Readers Digest, I believe. Maybe it does have something good in it occasionally.

III. A Great Challenge

On ward rounds during my junior year in one of Dr. S. T. W. Cull's scholarly discussions of some incurable disease, he gave us this quotation "Cure when possible, relieve often, comfort always." What a challenge to all in the great practice of medicine and surgery, but especially to family physicians!!!

There was a time when the possibilities of specific therapy and cure were greatly limited. Curative therapy constituted a much smaller proportion of our practice than it does today. Other physicians accepted this challenge greatly increasing the list of curable diseases. It is for us, the present physicians and research scientists, to extend these possibilities for cure to other and still other pathological processes so that this first admonition may have a yet greater place in our practice.

The patient in pain can usually have relief. The anxious mother can get some relief from her anxiety about her sick child by the assurances of her physician. The patient in labor can be given some

* Given at Senior Medical Day.

relief from her pain, but not completely many times, if we are to cure her by delivering a normal infant and restoring her to a healthy mother and wife. But we can relieve often.

However, when we have given of our fullest knowledge and experience but failed to cure and have given the fullest relief possible consistent with safety and yet have not completely relieved our patient, we can still comfort him with cheerful words, a pleasant voice, and a sympathetic attitude toward him and his family with all the reassurance possible.

During my resident training, it was my privilege to work constantly at the side of a highly specialized physician who was extremely kind to me but who nearly always used the back stairway of the hospital to avoid any contact with even an unconscious patient's family. And when he was sometimes forced to discuss the situation with the family he was abrupt and rude instead of kind and considerate of their feelings. Such treatment is not comforting.

Some of you may consider it below your professional dignity to sympathize with and comfort your patient and his family. Too many times after pronouncing a patient dead, we turn on our heel and walk away as if our full duty were accomplished. Could we not pause a moment to ask if we could call someone or help in any other way? Shouldn't we? I have seen two professionally, physically, and emotionally well developed physicians weep about the loss of a patient, not close bosom friends but patients who trusted them.

Of course, we cannot allow ourselves to become emotionally disturbed every time we have a death or a critically ill patient in our practice; but we can remember that we treat human beings with a heart that loves and is loved. We can give him the professional care of an understanding, sympathizing, comforting family physician.

IV. Summary

Yes, general practice challenges us to know and treat the entire human being as an individual whom we cure when possible, relieve often, but comfort always.

COMING ATTRACTIONS!

CLOSING MEETINGS OF BOTH **HOUSES OF CONGRESS,** SUMMER '54, WASHINGTON.
FALL CLINICAL ASSEMBLY ARKANSAS ACADEMY, LITTLE ROCK, OCTOBER 6-7.
SOUTHERN MEDICAL ASSOCIATION, ST. LOUIS, NOVEMBER 7-11.
ARKANSAS LEGISLATURE, FEBRUARY-MARCH, 1955, LITTLE ROCK.

RESOLUTIONS

DR. D. A. RHINEHART

WHEREAS, an all-wise providence has seen fit to remove from our midst, Dr. Darmon A. Rhinehart, who was our valued co-worker and a faithful member of the Pulaski County Medical Society, the Arkansas Medical Society, and the American Medical Association since 1922: We, the members of the Pulaski County Medical Society mourn and deeply regret his sudden departure;

WHEREAS, as a Physician in his chosen field of Roentgenology, he attained a great measure of distinction and won the respect and admiration of his colleagues, as well as the gratitude and love of a host of sorrowing people. Dr. Rhinehart taught Roentgenology and Anatomy for a number of years at the University of Arkansas School of Medicine, was active in the affairs of his local Society and was respected and admired by all whom he taught.

THEREFORE, be it resolved that the Pulaski County Medical Society express to his family the esteem in which he was held as a member of this Society and its heartfelt sympathy to the family at the untimely loss which it has sustained;

BE IT FURTHER RESOLVED that a copy of this resolution be made a matter of record in the minutes of the Pulaski County Medical Society; that a copy be sent to the family, and a copy to the Journal of the Arkansas Medical Society.

This resolution is respectfully submitted to the members of the Pulaski County Medical Society by your committee:

R. E. McLochlin, Chairman,
S. C. Fulmer.

Adopted June 7, 1954.

★ Editorial ★

"YOUR BUSINESS AND MINE"

25 May 1954

The Honorable Wilbur D. Mills,
House Office Building,
Washington, D. C.
Dear Mr. Mills:

As a result of your telegram of May 19th, advising of your motion to reconsider the vote to include physicians under Social Security, Dr. Brooksher and I telephoned leading physicians in many other states. We contacted the A.M.A. Washington office and the headquarters in Chicago apprising them of the situation and enlisting their aid in support of your motion. On May 21st we sent copies (Air Mail special delivery) of the enclosed letter to thirty (30) state medical society officers, one hundred sixteen (116) county medical society officers in fifty-eight (58) Arkansas counties, and the officers of our Woman's Auxiliary.

This morning I received the following telegram:

"Jenkins' motion to exclude doctors from Social Security passed House Ways and Means Committee by vote 15 to 10. There were 6 Republicans and 9 Democrats voted for the motion. Your congressman Wilbur Mills deserves thanks of doctors all over America.—Frank E. Wilson, director, Washington office, American Medical Association."

The doctors of Arkansas agree with Dr. Wilson and want you to know that your loyalty and fairness are recognized and appreciated.

Very truly yours,
Paul C. Schaefer,
Executive Secretary,
Arkansas Medical Society.

DUES—WHAT, AGAIN?

Yes, what again! Many times one hears the question asked, what do we get for our dues. **The fact that you are a member of the Arkansas Medical Society saved you $84.00 in additional tax this year. Next year it would have been $168.00.** Here is the story. Our dues paid for it.

Executive Secretary, Paul Schaefer, W. R. Brooksher, R. B. Robins, and others have been in constant touch with the scene in Washington. On Wednesday, May 19, the House Ways and Means Committee voted 12 to eight to force physicians and others on the "Social Security" tax rolls. Arkansas' Congressman, Wilbur Mills, wired Dr. Brooksher and Mr. Schaefer that if the physicians of the United States would get behind and protest, that he would see that a motion to reconsider was put before the committee. Thursday morning, May 20, Mr. Schaefer and W. R. Brooksher called key-men everywhere and asked them to alert the physicians that they were in danger. They contacted George Lull, Secretary of the A.M.A., who alerted his office. The A.M.A. Council on Medical Legislation was notified, both in Chicago and many members of that council were called directly. At least half of the directors of the A.M.A. were contacted and urged to start action. This was all done by long-distance telephone, to South Carolina, California, Nebraska, Tennessee, Washington, Illinois, Oklahoma, and other areas.

Within a few days, many letters, telegrams, and phone calls were coming into Washington. R. B. Robins (our Bob) got Mac Cahal of AAGP, who got the Academy's Commission on Legislation in action. He also sparked some friends to arrange a high level meeting with Mr. Leonard Hall, Chairman of the Republican National Committee, to see if the President could not be dissuaded from selling the physicians down the river when so many had voted for his ticket.

It was an eleventh hour race and the physicians won. By the following Tuesday, Congressman Mills had succeeded in getting Congressman Jenkins of Ohio to reintroduce the subject, and the physicians were relieved from the Social Security Tax.

The actions of the officers of the Arkansas Medical Society with the loyalty and alertness of Congressman Mills saved our necks—saved more than $100,000 to **Arkansas doctors alone, in taxes this year.** We will remember that. We salute Mr. Mills (Hon. Wilbur D. Mills, House, Office Building, Washington, D. C.), Mr. Schaefer, and our own President Brooksher, and others, for their generalship. Somehow having a part in a battle like this makes us proud of being a member of the Arkansas Medical Society. Makes us proud to know our dues are paid.—News Letter No. 51, Arkansas Academy of General Practice.

QUOTED:

From the Medical Society of the State of Pennsylvania

There are "1,113,004 beds in governmental hospitals and 460,010 in non-governmental hospitals, although the **latter cared for 74 per cent of all the patients."**

"The average length of stay in all general hospitals has been reduced from 9.8 days during 1952 to 9.3 days in 1953 while the average in govern-

mental general hospitals had a reduction from 16.4 to 15.1."

We believe any physician in Arkansas can take those figures and surprise any "Service Club" in any town in Arkansas. This is the most effective group of figures to support the Private Practice of Medicine we have ever seen. Can you use them?

The Wier Bill, H.R. 2341, is a direct attack on the professional opinion of the overwhelming majority of dentists and physicians who have endorsed and recommended the fluoridation of community water supplies. Because of the importance of this health measure, it suggested that each member of the Society send immediately his views on the Wier Bill, H.R. 2341, to the member of Congress from his respective district and to the Hon. Charles A. Wolverton, chairman, Interstate and Foreign Commerce Committee, House of Representatives, Washington, D. C.

Our dentist friends are fully arrayed against the Wier Bill. Let's give them a hand.

MEDICAL SOCIETY NAMES COMMITTEE FOR RURAL SURVEY

A six-man advisory committee to work with the University of Arkansas School of Medicine on the Rockefeller Plan for a study of Arkansas rural health facilities was appointed yesterday by the Arkansas Medical Society.

The committee will be headed by Dr. Louis K. Hundley of Pine Bluff, chairman of the Society's Council. Other members will be Dr. W. R. Brooksher of Fort Smith, president of the Society; Dr. J. M. Kolb of Clarksville, Dr. Fount Richardson of Fayetteville, Dr. Ben Saltzman of Mountain Home and Dr. H. W. Thomas of Dermott.

The Committee is expected to offer advice on the technical aspects of providing rural medical care.

The Rockefeller survey was approved by the Arkansas Medical Society last week at its annual convention. The study is to be financed by oil millionaire Winthrop Rockefeller who proposed the plan. The project is to include the establishment of a pilot clinic.—Arkansas Gazette, April 30, 1954.

TUBERCULOSIS ABSTRACTS

A Review for Physicians

ISSUED MONTHLY BY THE NATIONAL TUBERCULOSIS ASSOCIATION

CURRENT TRENDS IN TUBERCULOSIS

By MARY DEMPSEY
Statistician, National Tuberculosis Association
February 3, 1954

Probably more persons are under treatment for tuberculosis today than was ever before the case in this country. Most people are aware that the gradual decline in tuberculosis mortality has increased precipitately for the past few years; others know that the incidence of the disease is declining slowly; very few are conscious, however, that large and even increasing numbers of patients are coming under treatment.

Two factors help to account for the high prevalence of tuberculosis today—or rather for the high prevalence of KNOWN cases. Since 1945, tuberculosis case-finding activities have been carried on in many places and on a large scale. As a result a higher proportion of existing cases has been found than was previously known. The great majority (we hope) are receiving treatment.

Primarily as a result of new kinds of treatment patients, who would have died young now live until their disease is arrested. This fact with the augmented case finding has resulted in more patients under treatment than were previously known, even though morbidity and mortality are declining.

A sharp distinction should be made between incidence and prevalence. The annual incidence is the number of new cases which develop in a year; the prevalence of tuberculosis is the number of existing cases on any given date.

Slow decline in new reported cases.—The fact that today more patients with active tuberculosis are under care than ever before does not mean that there is any increase in the incidence. The number of **new** cases is declining slowly, while the

total of all **known** cases is showing a tendency to increase. During the period 1946-1948 mass community X-ray surveys were successful in locating a backlog of cases, many of which should have been reported years earlier; as a result, the number of new cases reported showed a definite increase. At that time, this advance was erroneously thought to represent a true rise in tuberculosis morbidity. Subsequent developments have confirmed the opinion that no actual increase had occurred.

The number of new cases reported has declined appreciably during the last two years. In 1952 the total number of new cases reported to health departments in the United States was 109,837, of which 85,607 were active or probably active.

Large numbers of cases are still unreported; but each year sees many cases reported which should have been known to health authorities years before. Probably fewer inactive cases will be reported in the future, now that agreement has been reached on the definition of a reportable case.

Decline in mortality.—Fifty years ago the tuberculosis death rate was 188 per 100,000 while today it is less than one-tenth that figure. Every agency and individual who has been interested in tuberculosis control shares in the credit for this sensational drop in mortality.

A second achievement rarely noted is the advancing age at death for those who died of tuberculosis. In 1924, the median age at death was 33.3 while in 1950 it was 49.7. Tuberculosis is rapidly becoming a disease of older men. Today half of all deaths from tuberculosis in this country are those of men 40 years of age and older.

The accelerated decline in tuberculosis mortality which has occurred recently is usually attributed to new forms of treatment. The use of excisional surgery and antimicrobial drugs have kept alive many who would otherwise have died from this disease. Some of them remain sputum-positive and the necessity for isolation is as urgent as ever. Thus, with a greatly lowered death rate from tuberculosis we have more patients under treatment than ever before.

Home care programs.—According to reports from widely separated states, the introduction of isoniazid has led to the establishment of home care programs for the tuberculous. We are told —rather indefinitely, it is true—that large numbers of patients are being treated at home with the result that vacant beds are reported from communities which once had long waiting lists. Is this a transitory occurrence? Or is it the beginning of a sustained trend toward home treatment? Today, no one seems able to answer these questions.

At this stage of development, organized home care programs under close supervision by clinics and public health nurses appear to offer a partial solution of the involved tuberculosis problem in large cities where health administration is highly organized. It is difficult to understand why such a program is needed or can prove successful in smaller communities which lack adequate clinic and public health nursing facilities.

Only time will tell how well the carefully supervised home care programs turn out. If the suspicion proves warranted that some patients are receiving drug treatment at home or at work with inadequate or no supervision, one does not know what to expect in the near future. Will these patients improve under such treatment? Or will they seek admission to tuberculosis hospitals in the near future? Are they spreading the disease? No one knows what is happening now nor do they know what will come next.

Cost of tuberculosis.—The excessive cost of the tuberculosis problem has seldom been faced by law-making bodies or health organizations. It is conservatively estimated that each case costs approximately $15,000; this amount includes cost of medical and nursing care, health education, case finding, rehabilitation, loss of the patient's wages, compensation, pensions, and relief payments to the patient's family while he is incapacitated. If the loss of patient's productive capacity and potential future earning power were included, the cost per case would be doubled.

One reason for the high estimated cost per case is the tendency toward relapse or reactivation which is an outstanding characteristic of this chronic disease. The average cost of maintaining a patient during his second or third hospital stay is from two to four times the cost of maintenance during his first stay. Many patients, especially those whose disease was not far advanced, have been treated by bed rest only during their first stay. When they return to the hospital, surgical treatment is often considered necessary. Some patients who have refused to accept surgical intervention will agree to it after readmission.

Cause and effect of poverty.—Few of us realize that tuberculosis is both a cause and an effect of indigency. It is simple to grasp the fact that poverty lowers resistance so that the disease spreads rapidly when families live on an inadequate or unbalanced diet, are crowded into insanitary homes, can obtain little education. But we do not always stop to think how directly tuberculosis leads to poverty in families where it did

not previously exist. A recent study of a sizable group of patients pointed out that less than two per cent of the patients' families were relief recipients at the time of diagnosis; upon being admitted to hospitals a few months later, 16 per cent were receiving public assistance. At the time of hospital discharge 50 per cent of the families of these same patients were on relief.

Estimates of the overall annual loss from tuberculosis in this country run to as much as six hundred million dollars. Even this astronomical sum does not include the cost of hospital construction, depreciation of hospital buildings, or the training of professional personnel.

OBITUARY

DARMON ARTELLE RHINEHART, 66, professor emeritus of radiology at the University of Arkansas School of Medicine, died May 22, 1954.

An outstanding member of organized medicine, Dr. Rhinehart was an influential member of the House of Delegates of the American Medical Association.

He was a past president of the Arkansas Medical Society, chairman of the section on Radiology of the Southern Medical Association, a diplomat of the American Board of Radiology, a fellow of the American College of Radiology and a past member of the Board of Trustees of the American Registry of X-ray Technicians.

His many years teaching in the University of Arkansas School of Medicine has endeared him to many Arkansas physicians.

He was a member of the Free and Accepted Masons, Consistory, Scimitar Shrine, Rotary, Country Club and Riverdale Club.

Survivors include his wife, Mrs. Lucy Askew Rhinehart; a daughter, Mrs. George Dittrich of Little Rock; a son, W. J. Rhinehart of Little Rock.

B. F. CASADA, 81, a practicing Hot Springs physician for 62 years, prior to his retirement several years ago, died May 2, 1954.

He was born in Montgomery County, May 5, 1873. Up until the time of his retirement because of ill health, he was a member of the Garland County Medical Society and was an honorary member of the Southern Medical Society.

He is survived by his wife, Mrs. Mary E. Casada, Hot Springs; one son, Carl Casada, Culver City, California; a daughter, Mrs. Jewel Feldmen, New York City.

FLOYD WEBB of Blytheville died at Chickasawba Hospital, May 28, 1954. Burial was in Hector Cemetery.

Dr. Webb, 66, suffered a heart attack at his home before going to the hospital. He was associated with his son, Dr. Jack Webb, in the Webb Clinic here.

Coming to Blytheville in 1935 after a residency at New Orleans, La., Eye, Ear, Nose, and Throat Hospital, he was a member of the Arkansas Medical Society and the American Medical Association. He also was associated with the American Legion and was a member of the Presbyterian Church.

Dr. Webb was graduated from University of Tennessee Medical School in 1913 and served during World War I with the Medical Corps.

Besides his son, he is survived by his wife, Mrs. Floyd Webb of Blytheville.

Honorary ball bearers were members of the Mississippi County Medical Association.

FRED DUNCAN, 78, died May 14, at a Fort Smith hospital after a long illness.

Funeral service was held at 3 p.m., Sunday, at the First Methodist Church. Rev. Oscar J. Evanson, pastor, officiated. Burial was in the Duncan cemetery under direction of Rice Funeral Home.

Survivors include the wife who is the former Dora Toler of Mulberry; one daughter, Miss Treva Duncan, librarian of Belle Point grade school in Fort Smith; and one son, Truman Duncan of Wichita, Kansas.

Dr. Duncan received his degree from the old Memphis Medical College in 1903.

He moved to Waldron from Mulberry seven years later.

Dr. Duncan was honored as one of 93 physicians to receive the "Golden T" award from the University of Tennessee for outstanding work in the Waldron community.

DANIEL KIRTLAND McCURRY, prominent Green Forest physician, died in the Baptist Hospital in Springfield, Mo., May 16, following a short illness.

He was born near Alpena, in Boone County, August 13, 1879. He was one of the few remaining "County Doctors," who was still practicing, and recently was given special recognition at a Medical Association meeting, held in Fort Smith.

Besides his wife, he is survived by two sons, Kenneth McCurry of Long Beach, California, and Virgil McCurry of Green Forest; two daughters, Mrs. Albert Bequette of Auburn, California, and Mrs. Homer Brown of Carlsbad, New Mexico.

Funeral services were held at 2:30 p.m., Wednesday, at the Methodist Church in Green Forest, with Rev. Rue Porter conducting the services.

JOHN SEAMANS, 82, Mansfield, Ark., died May 26 at his home after a short illness.

Dr. Seamans was a life-long resident and a practicing physician of Sebastian County for 51 years starting in Burnsville, Ark., in 1903 and moving to Mansfield where he was a physician for 28 years. He was an honorary staff doctor at Sparks Hospital and a member of the Scott and Sebastian County Medical Societies and of the Arkansas Medical Society.

Survivors include his wife, Oval Seamans, of the home; a daughter, Mrs. Yvette Lewis of Fort Smith; one son, Henry Warren Seamans of Fayetteville, Ark.; one step-daughter, Dolores Seamans of the home.

Funeral services were conducted at the Methodist Church of Mansfield. Rev. Paul Knight, Booneville minister, officated. Burial will be in the Mt. Harmony cemetery of Greenwood.

PROCEEDINGS OF SOCIETIES

Following a successful scientific meeting during the State Medical meeting, The Arkansas Obstetrical and Gynecological Society elected the following officers:

Dr. Charles R. Wickard, Little Rock, Ark.....President
Dr. John W. Jones, Texarkana, Ark. .....Vice President
Dr. J. F. Kelsey, Fort Smith, Ark.....Secretary
Dr. Robert W. Ross, Little Rock, Ark...Executive Committee
Dr. Wm. H. Breit, Harrison, Ark.

Notice of the program and date of the fall meeting of this society will be made in this Journal. Members of the State Medical Society interested in joining this group should contact the secretary.

J. F. Kelsey, Secretary.

The Independence County Medical Society and the Women's Auxiliary met for combined dinner and scientific session at the Batesville Country Club, May 11, 1954. Dale Alford, ophthalmologist from Little Rock, who is chairman of the Public Relations Committee for State Medical Society, gave a talk to the combined group on Public Relations. The scientific session was composed of a talk on a massive hemorrhage from the upper gastro-intestinal tract, with slides, by Joe Hardin, Little Rock.

The Independence County Medical Society also voted to contribute $20.00 for a suit for a Korean Physician. Routine business was conducted under the leadership of the president, Meryl Grasse of Calico Rock.

J. J. Monfort, Secretary.

The Association of Tumor Clinic Staff Members in Arkansas is as hard working a group as there is in medicine. These are the men who hold the Tumor Clinics (from four to ten meetings each per year) and give their time from their individual practices. Their most recent meeting was May 27 in Pine Bluff. Ralph R. Braund, Memphis, Director of the West Tennessee Cancer Clinic, was the speaker. W. H. Handley, Jr., El Dorado, presided. The Association heard W. R. Brooksher, Ft. Smith, and W. S. Orr, Jr., Little Rock.

Ernest T. Rouse, St. Louis, and Wendell T. Ward, Little Rock, addressed the 9th Councilor District Medical Meeting in Fayetteville, June 4. Officers elected for the coming year were: G. H. Butler, Fayetteville, President; Ross Fowler, Harrison, Secretary. The next meeting will be held December 3, in Harrison.

Craighead-Poinsett County Medical Society met June 2 at Jonesboro. L. H. Mayfield, Memphis, discussed "General Conditions of the Rectum." J. T. Herron and A. M. Washburn were guests and addressed the Society. The Society adjourned for the summer and will meet again in September.

The First and Third Councilor District Societies sponsored a scientific and inspirational program at Tyronza last Thursday with L. H. McDaniel as host, in Tyronza High School auditorium.

The scientific session had addresses by out-of-state men chosen for the honor by their prominence in the medical world. The list included George Lull, Dr. Elmer Hess, Erie, Pa.; Louis Bauer, Hempstead, N. Y.; Phil Thorek, Louis Krause, Baltimore, Md., and John A. MacCartney.

Specially honored at this meeting were George Lull, secretary, American Medical Association; R. B. Robins, past president, American Academy of General Practice; R. L. Sanders, president-elect, Southern Medical Association; C. P. Loranz, secretary, Southern Medical Association (42 years); R. C. Dickinson, immediate past president, Arkansas Medical Society; W. R. Brooksher, president, Arkansas Medical Society; W. L. Pressly, A.M.A. Doctor of the Year 1949; David G. Miller, former director of American Academy of General Practice.

Governor Francis Cherry gave the welcome address to the out-of-state guests, and the Hon. John McClellan, U. S. Senator, introduced Dr. Robins of Camden.

The inspirational speaker who concluded this session was Dr. Kenneth McFarland.

A barbecue dinner was served in the dining hall of the High School. Favors for men and women were distributed.

The entertainment session which was the concluding event was opened with a musical program by the Marked Tree Ensemble with Mr. Hodges, director and accompanist.

The after-dinner address was given by Edmund Harding of Washington, N. C., a humorist of note, who chose for his subject "What Size Hat Should A Doctor Wear."

Civic organizations of Tyronza, Marked Tree, Trumann, Harrisburg and Lepanto cooperated in giving the day's program.

The District Five Medical Society (5th Councilor District) met May 12 in Magnolia. Joseph W. Kelso, Oklahoma City, spoke on "Problems in Gynecology."

Jefferson County Medical Society inaugurated a post-graduate assembly to be held annually at Pine Bluff in May. It was held in connection with the Fourth Councilor District meeting and is set up to become an annual affair. Speakers included Harwell Wilson, Frank Tullis, and Hall S. Tackett, all of Memphis; Phillip Pemberton, Pine Bluff, and Anderson Nettleship, Little Rock. Credit for attendance has been assured by the Arkansas Academy of General Practice.

"SPARKS FROM THE SECRETARY"

J. J. MONFORT, Batesville

Are any of you readers Program Chairman for your County Medical Society? Let me suggest that Bill Dave Stewart and Frank Kumpuris of Little Rock have an unusual presentation of some talks on some surgical procedures and diagnoses in which actual demonstration of equipment is used. I recommend them to you. Also the chairman of the Public Relations Committee, Dale Alford, of Little Rock can present a most fascinating talk on Public Relations.

In case you would like a short, brief, summary of the doctor's position about chiropractors, may I suggest the letter of George Lull's in which the testimony regarding chiropractors being allowed to treat patients in Veterans hospitals as discussed by Dr. Lull in the letter to Sen. Edith Nourse Rodgers. I think that you will find it brief and to the point; might be a good idea to keep in your desk to show the occasional patient who desires to enter into an argument about the matter. You can obtain it by writing to the AMA and asking for that particular testimony letter.

Wonder what has become of the old fashioned nursing? Recently W. H. Calaway, Batesville, had a young male patient, unmarried who was very attractive. Some of the young, unmarried nurses were joking with him about it so he jokingly wrote on the bottom of the chart that this patient was to have T.L.C. For some reason this must not have been taught in recent years because several of the nurses were busy looking the thing up in the medical dictionary trying to find out what T.L.C. meant. It was only until one of the older nurses was asked that she, with much astonishment, explained that it meant Tender Loving Care!

PERSONALS AND NEWS ITEMS

Neylon David, Jr., is joining Harold Short in his clinic in Beebe this month.

"Doctor Jones Day" was observed in May at Hartford honoring E. B. Jones, 94-year-old practicing physician of Sebastian county. He has practiced in the Hartford area for over 60 years.

A. G. Talbot has moved his office from DeWitt to Lake Village where he has joined the infirmary staff. He is in general practice.

C. D. Tibbels, Black Rock, was an invited guest on the "Welcome Traveler" show in Chicago on June 1st. He has been recently honored for his diverse interests and his service to his community in local and national newspapers.

Helena hospital opened a new 16-bed annex for Negro patients in May.

John Rollow is building a new office at Bentonville.

James T. Wortham, acting head of the Department of Medicine at the University of Arkansas School of Medicine, has been appointed to represent Arkansas on the Board of Governors of the American Diabetic Association. He will be the senior delegate to the Assembly of Delegates of the Association.

F. Walter Carruthers, Little Rock, sailed early in May to attend various meetings in Orthopedic Surgery in London and other European cities. His trip included a visit to the Eastern Mediterranean area. Mrs. Carruthers accompanied him and they returned about July 1.

S. W. Hawkins, Fort Smith, who recently addressed the Louisiana State Medical Society on "Acute Abdominal Emergencies," was made an honorary citizen of New Orleans.

R. A. Downs, Fort Smith, attended the recent meeting of the American Urological Association in New York.

D. W. Goldstein, L. A. Whittaker and W. R. Brooksher, Fort Smith, conducted a diagnostic cancer clinic at Rogers June 4th under the sponsorship of the Benton County Medical Society and the Arkansas Division, American Cancer Society.

Roger B. Bost, Fort Smith, addressed the Pope-Yell County Medical Society June 10.

Johnson county physicians had more than a hundred guests at their annual banquet May 12. Earle H. Hunt was toastmaster. The usual Johnson county hospitality, camaradarie, and atmosphere prevailed.

George L. Mallory, Jr., North Little Rock, opened a new nine-room clinic in Rose City, last month.

John F. Rowland celebrated his 84th birthday at Hot Springs in May.

Robert Watson, Little Rock, attended the recent meeting of the Harvey Cushing Society in Santa Fe.

M. C. Hawkins, Jr., Searcy, joined the American College of Surgeons group, sailing aboard the Queen Elizabeth on May 5, for Europe. He will attend a series of surgical meetings and surgical clinics in England, Holland, Belgium, Switzerland, France and Germany.

At the Southwest Allergy Forum Meeting in New Orleans May 12th, Roy E. Schirmer of Fort Smith was elected president and Thomas G. Johnston of Little Rock was elected secretary for the ensuing year.

Dean Hayden C. Nicholson addressed the Forrest City Rotary Club May 26.

State Service Director Colonel Hansel T. Winters gave quotas of the doctor-draft for Arkansas. Two for June, two for July.

Frank Burton and Martin Eisele are building a new surgical clinic in Hot Springs.

Frank A. Lee, Vandervoort, was honored at a banquet May 20 by fellow practitioners of the district. John P. Wood was master of ceremonies and presented the 50-year pin of the Arkansas Medical Society.

Daniel McCall, Lawson, was the subject of a feature article in the El Dorado News and Times recently. The occasion was the anniversary of his 50 years as a practicing physician in Union county.

Two Randolph County physicians celebrated their 53 years in general practice in Pocahontas in May. Both J. W. Ryburn and J. W. Brown are in active practice and members of the Randolph County Medical Society.

Paul Hinds is being released from the Naval Hospital in Jacksonville, Florida, and will open his offices in Danville this month.

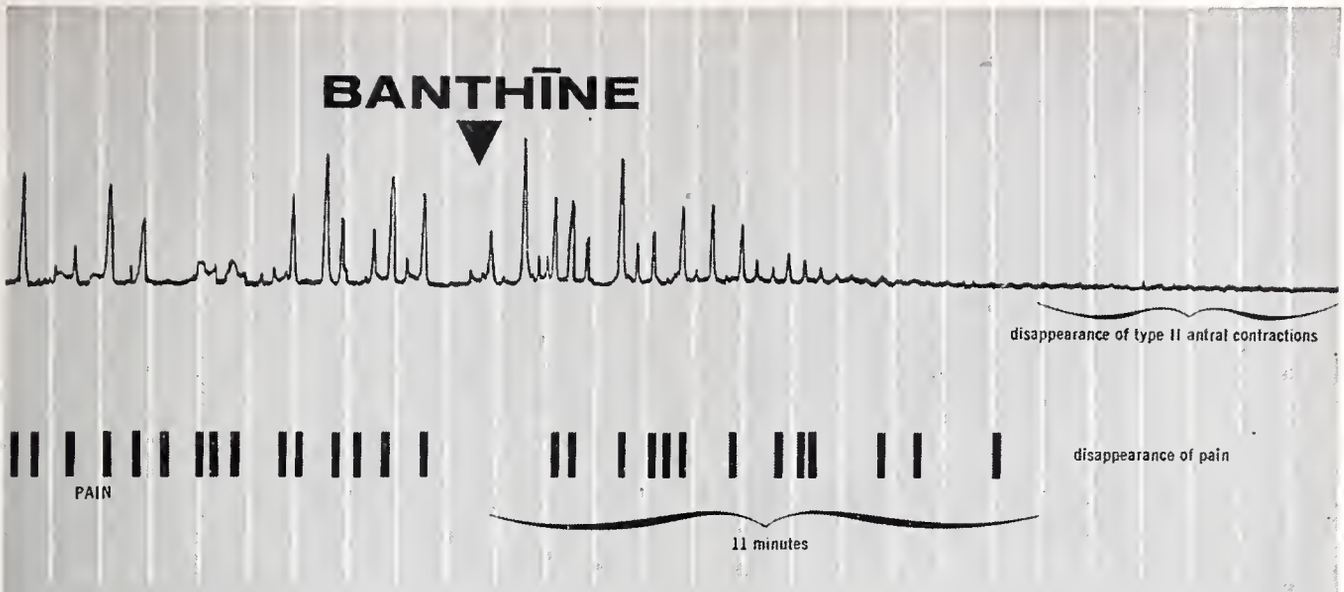
Wendell T. Ward opened an office in Fayetteville, July 1. He will limit his practice to radiology.

Drew Agar, Little Rock, and Driver Rowland, Hot Springs, addressed the Southwestern Chiropody Congress in Hot Springs in June.

W. O. Young, Jr., Russellville, is leaving for a three-years' residency in psychiatry in the Menniger Clinic in July.

Walter Allen Brooks, Little Rock, joined the Millard-Henry Clinic in Russellville, July 1.

Tom DePalma, Fayetteville, returned to his office in June after a year's residency training in Santa Barbara, California.



Effect of 100 mg. of Banthīne administered orally on antral gastric motility and duodenal ulcer pain.[2]

Hightower, N. C., Jr., and Gambill, E. E.: Gastroenterology 23 : *244 (Feb.) 1953*

Banthīne® Reduces Hypermotility and Hyperacidity in Peptic Ulcer

A recent evaluation of anticholinergic therapy in peptic ulcer emphasizes the fact that now the profession has at its disposal agents that are "effective in reducing both secretory and motor activity of the stomach."

The effect on motor activity is generally more pronounced and less variable than on secretion; pain relief is usually prompt; a high degree of effectiveness is noted in ambulatory ulcer patients.

Ruffin, J. M.; Texter, E. C., Jr.; Carter, D. D., and Baylin, G. J.: J.A.M.A. 153:1159 (Nov. 28) 1953.

With its proved anticholinergic effectiveness, Banthine has been found extremely useful in the medical management of active peptic ulcer, whether duodenal, gastric or marginal.

The immediate increase in subjective well-being and the simplicity of the Banthine regimen assures patient cooperation. The recommended initial therapeutic dose is 50 or 100 mg. (one or two tablets) every six hours around the clock, with subsequent individual adjustment. The usual measures of diet regulation, rest and relaxation should be followed.

Banthine is effective in other conditions caused by excess parasympathetic stimulation. These include hypertrophic gastritis, acute and chronic pancreatitis, biliary dyskinesia and hyperhidrosis. Banthine is contraindicated in the presence of glaucoma and should be used with caution in the presence of severe cardiac disease or prostatic hypertrophy.

Banthine® bromide (brand of methantheline bromide) is supplied in scored tablets of 50 mg. and in ampuls of 50 mg. It is accepted by the Council on Pharmacy and Chemistry of the American Medical Association. G. D. Searle & Co., Research in the Service of Medicine.

Brooks Teeter, Russellville, became associated with the Millard-Henry Clinic, July 1.

L. H. McDaniel, Tyronza, gave the Commencement Address to the June graduating class at Keiser High School.

WOMEN'S AUXILIARY

HOT SPRING COUNTY MEMORIAL HOSPITAL ORDERS BLOOD BANK

On May 11 the Medical Auxiliary of Malvern sponsored a Benefit Square Dance for the purpose of starting a fund for a Blood Bank. A tidy sum was netted from the dance and the citizens of Malvern and Hot Spring county made liberal contributions to the drive. At the monthly dinner meeting held in the home of Dr. and Mrs. W. F. Barrier, Mrs. John Cole, chairman of the drive, announced that the Blood Bank had been ordered. Eight Malvern doctors and their wives attended the dinner meeting. Special guests were Dr. and Mrs. Harvey Shipp and Dr. and Mrs. Clyde Rodgers.

The Auxiliary has a monthly luncheon meeting with a social and business session with plans being made for the following month's activities. Each member brings a toy for a young child. These toys are kept on hand at the hospital and given to the children to play with and take home.

Mrs. Raymond E. Peeples, President.
Mrs. R. V. McCray, Secretary.

Mrs. Mason Lawson was a guest speaker at the South Dakota State Medical Association's annual meeting in Huron May 18th.

PULASKI COUNTY ELECTS

Mrs. Edwin F. Gray has been elected president of the Auxiliary to the Pulaski County Medical Society. Other new officers are Mrs. Erner Jones, president-elect; Mrs. Ben Means, first vice president; Mrs. T. J. Raney, second vice president; Mrs. H. Ray Fulmer, recording secretary; Mrs. Guy R. Farris, treasurer; Mrs. Clyde Rodgers, corresponding secretary; Mrs. A. C. Kolb, historian; Mrs. T. D. Brown, parliamentarian, and Mrs. James Newbill, publicity.

GIFT TO HOSPITAL

The Greater Little Rock Federation of Women's Clubs presented a check for $979.64 for use at the new Medical Center to Dr. Hayden C. Nicholson, dean of the University of Arkansas School of Medicine. The money will buy a two-bed unit and surgical instrument for cancer treatment. Making the presentation were Mrs. E. B. Kelley, past president, and Mrs. Charles Fletcher, president.

BOOK REVIEWS

"Man's books are but man's alphabet."—Cincinnatus.

The Dynamics of Virus and Rickettsial Infections: Frank W. Hartman, M.D., Frank L. Horsfall, Jr., M.D., and John G. Kidd, M.D., Cornell University Medical College. New. 1954, New York, The Blakiston Co., Inc., p. 461. $7.50.

An International symposium sponsored by Henry Ford Hospital and the papers and discussion it elicited are here brought out in great detail. The text is the compendium of the leading thought and discussion of Virus and Rickettsial research throughout the world. There is a wealth of material for teachers, reference workers, bacteriologists, and others to be found, and many practical points for laboratory workers. To these workers, the book is highly recommended. It is doubtful if this up-to-date material is available in any other place. For practitioners, and to save time only, the use of an abstract of this excellent text is recommended.

A Manual of Tropical Medicine (Second Edition): Thomas T. Mackie, M.D., Colonel, M.C., A.U.S. (Retired), Chairman, The American Foundation for Tropical Medicine. George W. Hunter, III, Ph.D., Colonel, M.S.C., U.S.A., Chief, Section of Parasitology-Entomology, Fourth Army Area Medical Laboratory, Brooke Army Medical Center, Fort Sam Houston, Texas. C. Brooke Worth; M.D., Field Staff Member, Division of Medicine and Public Health, The Rockefeller Foundation. New, Second Edition. 907 pages with 304 illustrations, 7 in color. Philadelphia and London: W. B. Saunders Company, 1954. Price $12.00.

This second edition follows a nine-year interval of time, and the experience of the war years and post-war studies has been collected and used in the rewriting of this book. It is cumulative in its material and its list of collaborators assures the reader of its authority and of its being up-to-date. The text is direct in form, put in paragraphs with proper headings so that the student may find his requirements and also the busy physician can turn immediately to the treatment and epidemiology of a given case. This is an authoritative and comprehensive text and it is doubtful if there is a peer in its field. The paragraphs on diagnosis and on treatment are crisp, yet complete. The bolder-faced type makes the effort of reading more comfortable.

Fundamentals of Otolaryngology: A Textbook of Ear, Nose and Throat Diseases: By Lawrence R. Boies, M.D., Clinical Professor of Otolaryngology; Director of Division of Otolaryngology, University of Minnesota Medical School. New, Second Edition. 487 pages with 197 figures. Philadelphia and London: W. B. Saunders Company, 1954. Price $7.00.

This book succeeds in fulfulling the author's purpose of providing (1) a text for teaching under-graduate medical students the fundamentals of Otolaryngology, and, (2) a ready reference for the general practitioner. It is neither exhaustive nor exhausting, but covers the field in a logically sequential manner and employs a well-selected reference list at the end of each chapter to aid those who would look further into a particular subject. The index is full and specific for "ready reference."

This new edition presents the recent trends in therapy which are apparently proving more reliable and also advances in our knowledge of the physiology of Otolaryngology.

U. C. MEDICAL CENTER LIBRARY
AUG 17 1954
San Francisco, 22

AUGUST 1954

THE JOURNAL OF THE ARKANSAS MEDICAL SOCIETY

OL LI No. 3

FORT SMITH, ARKANSAS

SLEEP THAT MAKES THE DARKNESS BRIEF

'Seconal Sodium'

(Secobarbital Sodium, Lilly)

rapid action, short duration—patient awakens refreshed

In 1/2, 3/4, and 1 1/2-grain pulvules

ELI LILLY AND COMPANY • INDIANAPOLIS 6, INDIANA, U. S. A.

"How many of the

How many of these people need a doctor?

All of them!

Most of them are feeling fine and want to stay that way. And that's exactly why they need a doctor. For the surest way to *stay* healthy is to get in the habit of consulting a doctor regularly

A prompt report to your doctor of any real change in your physical condition may allow him to halt a disease before it becomes serious. A regular medical check-up may detect some illness before you are aware of it.

Copyright 1954—Parke, Davis & Company

And in treating and consulting with you through the years, your doctor builds valuable records on your physical assets and liabilities. He gets to know your emotional make-up. He can do more for you when he has an intimate understanding of you as a person.

Through your doctor you can take advantage of the vast resources of medical science and recent advances in treatment of many conditions.

Perhaps, at the moment, you don't have a family physician. If not, start making inquiries *now* — don't wait for an emergency to force you into a frantic search for a doctor.

You may wish to consider several doctors before you pick the one who is "right" for you Once you have made your selection, give him your complete confidence, as you would any other trusted member of your family circle. Remember, your doctor is the best "preventive medicine" your family can have.

PARKE, DAVIS & COMPANY
Research and Manufacturing Laboratories Detroit 32, Michigan

One of a series of messages on the importance of prompt and proper medical care, published by Parke, Davis & Company—makers of medicines prescribed by physicians and dispensed by pharmacists.

eople need a doctor?"

We're telling the millions of readers of LIFE, TIME,

Saturday Evening POST, NEWSWEEK, and TODAY'S HEALTH

-"All of them!"

ıe message shown on the opposite page is the ·est advertisement in Parke, Davis & Com-ny's "See Your Doctor" campaign which has en continuously published for the past 26 ars.

We believe it a part of our responsibility as a ıker of medicines to point out to the general blic that the doctor is the best "preventive edicine" a family can have.

To be of real service to the cause of Medicine, r messages must not only be given wide rculation but must be the type that people ll find interesting and readable. So we try hard to make the general subject of *prompt and proper medical care* "come alive" to the man on the street, the woman in the home.

Seven of these messages are reprinted in the booklet, "Your Doctor and You." If you wish a few copies for your reception room table, please let us know.

PARKE, DAVIS & COMPANY

Research and Manufacturing Laboratories, Detroit, Michigan

THE

Journal

OF THE

Arkansas Medical Society

Owned by

THE ARKANSAS MEDICAL SOCIETY

And Published Under Direction of the Council

FOUNT RICHARDSON, M.D., Editor

316 West Dickson Street — Fayetteville, Arkansas

MR. PAUL C. SCHAEFER, Business Manager

215 Kelley Bldg. — Fort Smith, Arkansas

The Advertising policy of this JOURNAL *is governed by the rules of the Council on Pharmacy and Chemistry of the American Medical Association.*

EXCLUSIVE PUBLICATION—Articles are accepted for publication on the conditions that they are contributed solely to this JOURNAL.

COPYRIGHT, 1954—By The JOURNAL *of the Arkansas Medical Society.*

NEWS—Our readers are requested to send in items of news, also marked copies of newspapers containing matter of interest to the membership.

OFFICERS OF THE ARKANSAS MEDICAL SOCIETY

W. R. BROOKSHER, President ..... Fort Smith
L. H. McDANIEL, President-Elect ..... Tyronza
T. P. FOLTZ, First Vice-President ..... Fort Smith
ELDON FAIRLEY, Second Vice-President ..... Wilson
R. H. WHITEHEAD, SR., Third Vice-President ..... DeWitt
J. J. MONFORT, Secretary ..... Batesville
DANIEL H. AUTRY, Treasurer ..... Little Rock
T. DUEL BROWN, Speaker, House of Delegates ..... Little Rock
C. C. LONG, Vice-Speaker ..... Ozark
MR. PAUL C. SCHAEFER, Executive Secretary
215 Kelley Bldg., Fort Smith

COUNCILORS

First District—JOE VERSER ..... Harrisburg
Second District—HUGH R. EDWARDS ..... Searcy
Third District—J. MAX ROY ..... Forrest City
Fourth District—L. K. HUNDLEY, Chairman ..... Pine Bluff
Fifth District—D. E. WHITE ..... El Dorado
Sixth District—HARRY E. MURRY ..... Texarkana
Seventh District—H. KING WADE, JR ..... Hot Springs
Eighth District—H. ELVIN SHUFFIELD ..... Little Rock
Ninth District—FOUNT RICHARDSON ..... Fayetteville
Tenth District—J. M. KOLB ..... Clarksville

VICE-COUNCILORS

First District—WAYNE WORKMAN ..... Blytheville
Second District—JOHN SNEED ..... Conway
Third District—J. P. WILLIAMS, JR. ..... Brinkley
Fourth District—H. W. THOMAS ..... Dermott
Fifth District—GEORGE BURTON ..... El Dorado
Sixth District—CHARLES YARBOROUGH ..... Texarkana
Seventh District—RANDOLPH ELLIS ..... Malvern
Eighth District—ROBERT D. JONES ..... Little Rock
Ninth District—LEE A. DEAN ..... Rogers
Tenth District—LOUIE A. WHITTAKER ..... Fort Smith

Notice on Form 3578-P to be sent to the Arkansas Medical Society, 215 Kelley Building, Fort Smith, Arkansas. Published monthly under direction of the Council, Arkansas Medical Society, at Fort Smith, Arkansas. Vol. LI. No. 3. Subscriptions $3.00 a year. Single copies, 50 cents. Entered as second-class matter, Sept. 23, 1947, at the post office at Fort Smith, Arkansas, under the Act of Congress of March, 1879. Acceptance for mailing at special rate of postage provided for in Section 1103, Act of October 3, 1917, authorized August 1, 1918.

• SPECIAL FEATURES

Committee on Cancer Control 61
Physiological Surgery of the Nasal Septum and Associated Structures 62
Cystic Lung Disease and Other Ventilatory Problems 65
Late Post-Partum Bleeding 70
Report of the San Francisco AMA Meeting 72

• FEATURES

Editorial 73
Letters 73
Coming Meetings 73
Public Relations 74
Obituary 75
Arkansas Traveling 75
Proceedings of Societies 76
University of Arkansas Graduation 76
Personals and News Items 77
Tuberculosis Abstracts 79
Book Reviews 80
Arkansas Medical Society Committees for 1954 81
County Medical Societies of the Arkansas Medical Society Officers for 1954 82
Amebiasis a "Poorly Reported" Disease 83

The JOURNAL
OF THE ARKANSAS MEDICAL SOCIETY
PUBLISHED MONTHLY UNDER DIRECTION OF THE COUNCIL

Vol. LI August, 1954 No. 3

Committee on Cancer Control

C. A. ARCHER, M.D., Chairman

PROGRESS IN CANCER CONTROL

Early diagnosis constitutes the present answer to the problem of the control of cancer. Early diagnosis is the serious responsibility of the first physician consulted by the patient. Early diagnosis can be made by the personal physician of the patient and the hope that each doctor's office may become a cancer detection center is not too optimistic for attainment. Cancer originating in the mouth, the skin, the cervix, the rectum, the lung, and the breast comprises about 60% of the cancer deaths in women and about 25% of cancer deaths in men. These cancers are distinguished in that they may be discovered while small and without symptoms and that each shows a high cure rate with proper and adequate treatment. The public is becoming increasingly aware of the magnitude of the cancer problem as it affects the individual. Physicians must become more aggressive and hopeful in their attitude, and in so doing, will they find early, curable cancer.

PHYSIOLOGICAL SURGERY OF THE NASAL SEPTUM AND ASSOCIATED STRUCTURES

RALPH H. RIGGS, M. D.*
Shreveport, La.

The contents of this effort are not original with me but are an accumulation of the knowledge and principles taught by my friend, Dr. M. H. Cottle of Chicago, during my presence many times at his course titled: Introduction to Fundamentals of Reconstructive Surgery of Nasal Septum and External Nasal Pyramid. He is one who has shared "his all" with me, and others who have so desired. Through his untiring efforts many have received instruction in modern rhinological surgery.

Physiological surgery of the nasal septum and its associated structures has been neglected by us to the point that even now another specialty feels that we are "stepping on their toes" and furthermore that we may not be qualified to perform such procedures. Unfortunately this may be partly correct, but fortunately more of our specialty are becoming enlightened so maybe a new era is forthcoming in rhinology.

Until the early 1940's rhinological surgery consisted of the submucous resection, the removal of polyps and various degrees of sinus surgery. At that time dissatisfaction was so general that the public and many of the medical profession looked upon any nose operation with great disfavor. In fact some of our own specialty practically discontinued the septum operation.

During the past decade the complete septum operation, its reconstruction, and surgery of the external nasal pyramid has been added.[1] [2] A renewed interest has been created in this subject due to the newer concepts of nasal physiology.[3] These have been described repeatedly by Cottle during the past few years.

It is the purpose of this paper to bring to your attention the importance of preserving and restoring nasal function by means of surgery of the nasal septum and its associated structures.

Only enough of the anatomy will be discussed here to re-emphasize once again the importance of the upper lateral cartilages and lobule.

The upper lateral cartilages are in reality wings of the septal cartilage, of which they are an integral part, and together with which they form the cartilaginous vault. The relation of these cartilages to the septum varies from above downward; in other words, the angle of attachment as well as its consistency changes. Above the cartilage is heavier or thicker whereas below it is lighter or thinner. The cephalic third of the upper lateral cartilage is continuous with the septum, while the caudal two-thirds is separated from the cartilaginous septum by a narrow cleft containing fibrous tissue.[4] The terminal portion is usually not attached to the septum. This anatomic arrangement enables the lower part of the cartilage to move in and out from the septum in a "valve like" manner; in fact, this region is actually the "valve" of the nose. One must know that it may not be possible to make the middle or upper one-third take over what is normally the specific function of the specialized terminal third.[5] This is of great importance when one contemplates shortening of the nose to include shortening of the upper lateral cartilages.

Variations in the size and shape of the upper lateral cartilages may exist in different individuals and various degrees of asymmetry may be found in the two upper lateral cartilages in the same individual. At times there is even a curling cephalically or lateralward of the terminal portion which will cause an interference with normal function.

These cartilages are overlapped along their cephalic borders by the nasal bones, forming a firm side-to-side apposition with them and being separated from the bone by only a single, thin, connective tissue membrane consisting of fused periosteum and perichondrium. The upper lateral cartilages are further bound to the nasal bones by supporting fibers which pass dorsal to the bones. This firm union of the upper lateral cartilages and the nasal bones forms the "key stone" area.

There are individuals who have practically no nasal bones in which case most of the dorsum is formed by the upper lateral cartilages and septum. Others may have very long nasal bones and very short upper lateral cartilages. It is important to know what is present for there have been patients with short upper lateral cartilages in whom the valve of the nose has actually been "cut off" in the process of shortening the nose.[6] Also in the individual with very short nasal bones it is possible, with a cartilaginous hump, to actually "cut off" the nose. Such a case has been seen by the author.

The lobule contains the lobular (alar) cartilages, the columella, the alae and the vestibule. Actu-

* Read before the Seventy-eighth Annual Session Arkansas Medical Society, Fort Smith, April 20, 1954.

ally, the lobule is an organ by itself, connected to the other parts of the nose, externally by skin only and inside by connective tissue fibres and skin. The lobular cartilage is somewhat U shaped, it has a lateral crus, a dome and a medial crus. The lateral crus helps form the alae and the lateral wall of the vestibule. The medial crus helps form the columella. The dome, together with its mate of the other side, forms what is generally called the tip of the nose.

The cephalic margin of the lobular cartilage overlies the caudal end of the upper lateral cartilage. The action of these two cartilages plays an important part in normal breathing. The upper lateral cartilages in their relationship to the septum are affected greatly by the lobular cartilages and the rest of the lobule.

The columella and membranous septum divide the inner part of the lobule into two compartments known as vestibules, which are the entrances to each "nose proper." There are several prominences within the vestibule whose function is to delay and direct the air stream into the nasal cavity. These landmarks are a part of either the upper lateral cartilage or the lobular cartilage. They are the caudal margin of the outer extremity of the lateral crus, the caudal margin of the upper lateral cartilages, a cul-de-sac located between the lobular and upper lateral cartilage, and the posterior extremity of the medial crus. Destruction of this normal anatomy in not conducive to good nasal function.

In performing operations on the septum we must keep in mind its relationship to the upper lateral cartilages and the lobule, as well as the lateral nasal walls and the nasal bones. Operative correction of abnormalities of the septum, or any of its associated structures without due consideration of the other parts of the nose will invariably result in a poorly functioning nose.

Cottle [5] has divided septal pathology into deviation, obstruction, impaction and tension. Deviation of the septum requires operation only when there is enough deviation in areas that cause trouble. Obstruction implies intermittent blockage of the passage of air through one or both sides of the nasal cavity due to a pathologic septum. Treatment is frequently surgical correction. Impaction means that the septum is all the way over to the lateral wall, and movement of air in that area is completely blocked at all times. This condition is always treated surgically. Tension conditions, which may produce serious functional disturbances, may be associated with any of the above named pathologic alterations and also includes practically straight septums. Examples are noses which are high and thin, and long noses in which the hard septum encroaches upon the membranous septum and columella. Excessively shortened though straight septums may also produce symptoms of tension. Tension can be relieved only by reconstructing the septum to fit the other parts of the nose.

Proper functioning may also be affected by a number of other conditions; for example, a twisted nose, saddle nose, deformed lobule, the long nose and drooping tip. A large hump can alter the eddying of the air. Dislocation of the caudal end of the septum and a depressed tip are frequently encountered and septal surgery alone will not correct these conditions. Proper direction of air currents, the intensity of the flow, and the amount of air which may flow through the nose in a given length of time, provide different considerations to guide in the selection of patients for nasal surgical procedures and for deciding whether this patient needs an operation on the septum, external nasal pyramid, or any combination thereof.[7, 8]

Since deformities of other parts of the external nose often accompany a pathologic septum, a more extensive and flexible procedure than simple submucous resection is required. The Cottle trained men know that reconstruction of the septum is a good operation, because it permits correction of all or any portions of the hard and membranous septum with avoidance of surgical trauma to uninvolved structures. It can be performed at the same time that neighboring structures, which are associated with the deformed septum in disturbing nasal function, are being corrected. The aim of this type of surgical treatment is to produce a good hard septum, a good membranous septum and a good semi-membranous septum (columella). This will help preserve septal functions, prevent and correct saddling, prevent and correct retraction of a columella, and correct tensions due to conditions already described; moreover, the valve of the nose can be retained and may even be "adjusted."

In addition to restoration of normal anatomic relationships, Cottle teaches other requisites of a successful septal operation. First, vertical incisions in the mucosa should be avoided because scarring in the nasal mucous membrane interferes with normal function; moreover, care should be exercised not to injure the perichondrium and periosteum; adequate exposure of all parts of the septum should be feasible and, finally, the incision should be easily approximated with sutures so as to permit healing by primary intention, and the

relation of the septum to adjacent structures should be established. Cottle's technic of septum reconstruction not only meets all these requirements but it is exceptionally safe when the combined septal operation and rhinoplasty are indicated.

The following illustrative cases are presented:

Case 1:

J. L., a 13-year-old boy fell on his nose 5 years previously. He had an obstructing septum, a retracted columella, and a saddling of the cartilaginous dorsum. At operation the septum was reconstructed and a cartilage graft was placed over the dorsum. The septum operation not only

Fig. 1 Case 1

relieved the nasal obstruction but the retracted columella was also corrected. The cartilage graft relieved the saddling and helped elevate the tip. Improvement in general health was immediate.

Case 2:

E. G., a football player had an external deformity and an obstructing septum although he had had a previous submucous resection operation.

Fig. 2 Case 2

Treatment consisted of reopening and repairing the septum; lobule surgery and placing the external pyramid back in the midline. This resulted in improvement in both respiration and appearance.

Case 3:

Miss W. B. had been in an automobile wreck several months previously. Examination revealed an obstructing septum with a caudal dislocation,

Fig. 3 Case 3

a flattened injured lobule, slight saddling of the cartilaginous vault, and a widened bony arch. Surgery consisted of reconstructing the nasal septum, extensive remodeling of the lobule, including removal of wedges from the foot of the alae, narrowing of the bony arch, placing a cartilage graft over the entire dorsum and a button over the tip through the incision made for work on the lobular cartilage; no intercartilaginous incisions were made. Needless to say, in a young woman such as this, improvement was both physiological and psychological.

Case 4:

C. D. had a hump and a deviated septum in the valve region. There had been an injury to the

Fig. 4 Case 4

upper part of the nose as evidenced by a depressed scar in the region of the glabella. The deviated septum was relieved by trimming the cartilaginous dorsum during the hump removal. The bony hump was of particular interest due to the size of the frontal spine. Complete removal of it was necessary to make possible apposition of the nasal bones. This resulted in practically normal respiration and considerable psychologic improvement.

Conclusion

Physiological surgery of the septum and its associated structures means "the preservation and restoration of nasal function." This is the theme of Cottle's teachings, and should be the objective of all present day rhinologists.

REFERENCES

1. Cottle, M. H. and Loring, R. M.: Corrective Surgery of the External Nasal Pyramid and the Nasal Septum for Restoration of Normal Physiology. Ill. Med. Jour., 90:119-131, (Aug.) 1946.
2. Cottle, M. H.: Modified Nasal Septum Operations. E.E.N.T. Monthly, 29:480-484, (Sept.) 1950.
3. Riggs, R. H.: Influence of New Concepts of Nasal Physiology on Nasal Operations. Journal of Louisiana State Medical Society, 105:217-220, (June) 1953.
4. Kirschner, John: Cottles 1953 Manual of Introduction to Fundamentals of Reconstructive Surgery of Nasal Septum and External Nasal Pyramid. P. 49.
5. Cottle, M. H.: The Role of the Rhinologist in Rhinoplasty. Laryngoscope, Vol. 63, No. 7, (July) 1953.
6. Riggs, R. H.: The Relation of Septum Reconstruction to External Deformities of the Nose. The Laryngoscope, 63:4, pp. 293-303, (April) 1953.
7. Cottle, M. H. and Loring, R. M.: Newer Concepts of Septum Surgery: Present Status. E.E.N.T. Monthly, 27: 403, (Sept.) 1948.
8. Cottle, M. H. and Loring, R. M.: Surgery of the Nasal Septum, New Operative Procedures and Indications. Annals, Otol., Rhino. & Laryng, 57:705, (Sept.) 1948.

CYSTIC LUNG DISEASE AND OTHER VENTILATORY PROBLEMS *

W. O. ARNOLD, M.D.†

Temple, Texas

Today, chronic bronchopulmonary disease, with disability, is increasing concurrently with the average life span of man, which has lengthened 21 years since 1900.

Exposure to gases, smoke, dust, etc., producing repeated bronchial irritation and cough over a long period of time, results in an inadequate bronchial tree, with the inability to eliminate its own secretions. The ball-valve effect of retained secretions and bronchial spasm, referred to lightly in the past as "chronic bronchitis," carry with them ultimate pulmonary disability of a much more serious nature than was supposed heretofore. Fungus disease, Boeck's sarcoid, and fibrosis of unknown etiology, as well as industrial hazards, all are etiological factors. In addition, with the advent of antibiotics and the advances made in thoracic surgery, more patients are recovering from the initial lung disorder, to suffer later from consequent fibrosis or lack of adequate function of the lung.

Although the etiology may vary all the way from a simple chronic bronchitis over a long period of years (example—"smoker's syndrome") to fibrosis secondary to disease, whether it be due to the healing of an old tuberculosis or fungus disease, the ultimate disability is the same—that of pulmonary insufficiency or decompensation.

The lungs are much larger than necessary to meet the resting needs of the body. Manual labor can be accomplished with one normally functioning lung. There can be a great deal of destruction of lung tissue for a long time, without apparent disability. Interference with ventilation in the bronchial tree may go on for years before sufficient changes occur in the lung parenchyma to produce even the first symptoms of a failing lung—that of early morning cough with dyspnea.

What occurs after years of prolonged bronchial irritation, chronic cough, and secondary infection can be visualized readily. There is swelling of the bronchial mucosa; retention of mucus; and gradual loss, because of prolonged secondary infection, of ciliated epithelium, with their sweeping movement in the bronchiole.

Because of the mechanism of narrowing and shortening of the bronchiole on expiration, the obstruction is greatest in the expiratory phase (bronchial spasm). Since the bronchi both length-

* Read at the Seventy-eighth Annual Session, Arkansas Medical Society, Fort Smith, April 20, 1954.

† From the Department of Diseases of the Chest, Scott and White Clinic.

en and widen during inspiration, a mucous plug has a ball-valve effect in a bronchiole 1 mm. in diameter; thus, air is allowed to pass into the alveolus on inspiration and is trapped on expiration. The delicate alveolar wall cannot withstand much of this pressure, and soon the alveolar septum is destroyed, along with its vascular bed. This is the early beginning of a cyst or emphysematous bleb. If this cycle can be interrupted, before too much alveolar destruction occurs, ultimate pulmonary insufficiency may be prevented. If, however, this vicious cycle is allowed to continue, a generalized obstruction of the smaller air passages occurs, with more destruction of alveoli, to the point where the lungs lose their elasticity, become unable to recoil passively on expiration, and remain in a state of hyperinflation on expiration. The diaphragm ceases to perform efficiently, and, ultimately, from lack of use it becomes fixed, flattened, and the muscle fibers deteriorate. The patient then is forced to breathe with the accessory respiratory muscles, which results in a definite interference with the PO_2 - PCO_2 exchange from alveolus to capillary. It is at this stage that cyanosis may appear. The difficulties have passed from a simple ventilatory problem to an alveorespiratory problem, and anoxia is sufficient to manifest itself in obvious cyanosis.

The PO_2 tension falls below the normal 100 mm. in these cystic areas, and, since the O_2 tension in the capillary returning from the right heart is approximately 40 mm., the PO_2 does not readily pass across the already thickened membrane into the capillary. This prolonged anoxia again produces an added vicious cycle, that of secondary polycythemia, increase in the viscosity of the blood with added weight and work on the right heart. Continuation of the process long enough completes the picture, that of pulmocardiac disease, or cor-pulmonale. Other factors play a part, for instance, the PO_2 tension in these dead spaces is low, because of improper ventilation. It is thought by some, that CO_2, being a readily diffusible gas, will pass back into the capillary, and the dead space, or cyst, becomes and behaves like an atriovenous shunt.

There is some reason to believe that the capillary endothelium in the alveolus depends upon the alveolar air for its oxygen supply. These capillaries leak due to the anoxia filling the septa with localized edema, and further interfering with the O_2 - PO_2 exchange between the alveolus and capillary. In deciding on the proper treatment, it is necessary to understand where the interference to ventilation is: 1). Is it due to bronchial spasm and retained secretions only? 2). Is interference confined to the bronchial tree alone? (Sometimes just the stopping of smoking is sufficient.) 3). Has there been further destruction with loss of capillary bed, elasticity, with resulting hyperinflation and increased residual volume, as in emphysema? 4). Is there thickening between the alveolus and the capillary, as in pulmonary fibrosis, with a decrease in residual volume? 5). Are there changes in the endothelium of the capillary, as in Ayerza's disease? There may be a combination of one or more of these conditions.

The diseases classified as producing pulmonary insufficiency show considerable variation in gross and microscopic pathological appearance, but they display a striking degree of similarity in their clinical manifestations in response to treatment. In general, patients with pulmonary insufficiency may be considered as being in a state of pulmonary decompensation, in much the same way as current knowledge permits a concept of cardiac decompensation, wherein heart failure is due to any number of etiological influences. These influences may act alone or together, producing a similar clinical picture, and responding to a general therapeutic program with a common denominator in most instances, but modified, of course, by the particular circumstances in a given case.

TREATMENT

Usually, a patient with alveorespiratory or cardiopulmonary disease is confined to the hospital for a minimum of five days. A combination of therapeutic measures based on physiologic principles will greatly benefit the pulmonary invalid. These measures are: 1). relief of bronchiolar spasm and promotion of bronchial dilatation, 2). removal of secretions and bronchial plugs by rotary postural drainage, 3). control of infection, 4). oxygen therapy, and 5). careful training of the patient and correction of anatomical defects.

1. Relief of bronchiolar spasm and promotion of bronchial dilatation.

Vaponephrin and Isuprel have proved to be of considerable value in relief of bronchiolar spasm. If there are side reactions, the milder Aerolone Compound may be used.

The patient with chronic pulmonary disease often finds himself uncomfortable upon arising, because of bronchiolar spasm and retained secretions. For relief, nebulization by continuous flow of 5 to 6 liters of oxygen, for 3 to 12 minutes, followed by rotary postural drainage, is recommended. Aerosols may be introduced along with

intermittent positive pressure breathing (IPPB) with the Bennett valve.

Aminophylline, when given on an empty stomach, has been shown to be an effective bronchodilator. Dosages of 0.2 gm., orally, 30 minutes before meals and at bedtime, are prescribed. In a few patients, nausea may occur, but after repeated trials and reassurance, a large dosage usually can be tolerated.

Iodides may be used, but should be omitted during an acute respiratory infection, as iodides are excreted by the bronchial glands and may produce more irritation of the respiratory mucosa. Hydryllin Compound has the advantage of Aminophylline and iodides in combination with Benadryl. Toryn, 10 mg. every 6 to 8 hours, appears to be an effective antitussive agent. Combinations of Orthoxine and Aminophylline may be used, especially if Aminophylline produces side reactions.

2. Removal of secretions and bronchial plugs by rotary postural drainage and detergents.

In the patient with pulmonary insufficiency, destruction of elastic fibers in the lung, loss of smooth muscle tone, and destruction of the ciliary epithelium in the bronchiole favor formation of small bronchiolar plugs, local bronchiospasm, and mechanical obstruction. These interfered with the movement of air into and out of the bronchopulmonary segment distal to the plugged bronchiole, block localized areas of alveoli, and result in hypoxia and anoxia. The patient is unable to drain these secretions adequately, but this situation can be overcome to some extent by rotary postural drainage.

For **rotary postural drainage,** the patient lies on a light cot or bed, with the foot of the bed elevated about 8 inches, placing the thorax at a 30 to 35 degree angle. For comfort, the patient may place his head on a small pillow, provided it does not allow the shoulders to be elevated. He is instructed to lie on his back, on each side, and on his abdomen for 5 to 8 minutes in each position; the whole process requiring only 20 to 30 minutes. Since the bronchioles are directed in many different directions, horizontally, vertically, and in all degrees of obliquity between, such a method of rotation facilitates drainage of most of the bronchopulmonary segments. The procedure should be practiced at least twice daily, preferably, just after awakening and just before retiring. Aerosol nebulization, preceding the postural drainage, will relieve some bronchiolar spasm and facilitate better drainage.

In comparison with the old, uncomfortable method, in which the patient leaned over the side of the bed with his head practically touching the floor, rotary postural drainage seems acceptable. In most instances, the patient will cooperate, once he understands the reasons for the treatment and the importance of keeping the bronchopulmonary segments clear of secretions.

Results in some instances are rather dramatically quick, but, for the most part, improvement is not evident until after a week or two of continued application of the procedure. If the physician will take the time to explain to the patient that large amounts of secretions may not be immediately forthcoming, but that persistent application of rotary postural drainage for several days will result in symptomatic improvement, the patient will not need visible evidence of copious amounts of secretion to be convinced of the value of the procedure.

In addition to overcoming mechanical defects of the bronchial tree, rotary postural drainage probably is useful as an exercise for impaired movement of the diaphragm.

The use of detergents, such as Alevaire, is helpful in liquifying ropy sputum. A continuous mist of the detergent may be used in an oxygen tent, or nebulization of a substantial quantity (2 cc.) just before postural drainage. During and after an acute tracheobronchitis, a detergent may become almost life saving in some instances. These detergents may be used in conjunction with other treatment, if and when ropy, tenacious sputum warrants it.

3. Control of infection.

When infection is present, it is quite understandable how normal bronchial secretions may become stagnant and even result in the formation of mucous plugs. Such a situation is extremely favorable for the development of secondary infection, with a resultant inflammatory reaction, which, whether it be rather severe or low-grade, produces more spasm and increased secretions. For control of such infection, the predominating organisms are usually responsible for the choice of antibiotics. Penicillin is used for the gram-positive organisms. Neo-Penil has been employed recently with good results. Streptomycin and Terramycin are added, if gram-negative organisms are present.

After a respiratory infection, the patient should always have antibiotic therapy, until all infection has cleared, and rotary postural drainage should be practiced more often during this time.

It is well to remember that any form of bronchial or bronchiolar obstruction or interference with the exchange of air in and out of the lungs, as in the case of an acute respiratory infection with exudates, can in a short period interfere with the alveolar respiratory function and in time with the cardiopulmonary function of a patient who is already handicapped with poor pulmonary function from one cause or another. The increased load placed on the cardiopulmonary system or increase in pulmonary hypertension ultimately may produce cor-pulmonale.

4. Oxygen therapy.

Oxygen therapy in patients with ventilatory insufficiency alone is not necessary. When alveolo-respiratory insufficiency is present, oxygen is indicated.

An attempt has been made to keep oxygen therapy inexpensive and adaptable, with sufficient simplicity that the patient can and will practice it daily at home. We believe that the use of expiratory positive pressure oxygen therapy, using the O.E.M. meter mask, is the most practical, effective, inexpensive means of oxygen administration. The cost of the complete mask and gauges is minimal in comparison with other positive pressure breathing equipment.

Positive pressure breathing in expiration (O to 4 cm. water) by exhaling the expired air into the narrow orifice of the metering disc sets up a gentle positive pressure. After determining that the patient can tolerate oxygen and that there will be no oxygen-induced narcosis, 100 per cent oxygen is used. An oxygen treatment may be taken from twice daily to every 2 to 4 hours for 5 to 20 minutes, depending on the degree of dyspnea and the functional incapacity of the patient. Barach has stated that this type of oxygen therapy produces bronchial and bronchiolar dilatation and relief of spasm. It is probable that expiratory positive pressure oxygen therapy also improves collateral respiration through Loosli's alveolar pores.

Twenty patients on expiratory positive pressure have been followed at monthly intervals for at least a year. On the second to third month, a change in the type of breathing from thoracic to abdominal breathing has been noted. Apparently, this type of positive pressure also may act as an exercise for the diaphragm. Subsequent studies may or may not prove this observation.

The majority of these patients are using the mask in the morning, once in the early afternoon, and in the evening. Nebulization with an Aerosol, before the oxygen treatment or before each postural drainage, varies in each individual case. Improvement for this group of patients has been encouraging. By improvement, we mean a sense of well being, more ease in breathing and in performing activities which previously were difficult or impossible, as well as an increase in appetite and strength, and less fatigue. As examples of improvement: one patient was able to do a full day's work as a clerk. Prior to treatment, he had been unable to do any work. Another patient could walk half a block in comfort, whereas, prior to treatment, he was bedfast, in respiratory acidosis, and unable to take but a few steps.

In cardiopulmonary cases, treatment includes digitalis, diuretics, limitation of activity, and phlebotomy when polycythemia and greatly increased blood volumes are present.

Positive pressure therapy with the O.E.M. meter mask differs from other positive pressure therapy. Inspiratory positive pressure breathing has been employed with good results, and has the advantage of nebulizing an aerosol at each inspiration. (IPPB), however, is not easily adaptable to home usage, and since many patients cannot afford such an expensive respirator, their treatments are limited to shorter periods of time, weeks or months —or they are unable to report regularly for treatments.

It is well to note certain hazards of oxygen therapy. In the presence of depressed central chemoreceptors (medullary respiratory centers), the peripheral chemoreceptors (aortic and carotid bodies) maintain the breathing. In severe hypoxia, high concentrations of oxygen given too rapidly may abolish this activity and apnea is likely to occur. Shock is the one contraindication to the use of the O.E.M. meter mask. Patients who demonstrate myocardial ischemia are prone to sweat after 15 minutes of expiratory pressure and are advised to limit treatment to 10 minutes. There have been no untoward results with 20 patients observed. All but two of these patients have maintained improvement or have progressively improved.

5. Careful training of the patient and correction of anatomical defects.

The patient must have a thorough understanding of his problem and of the treatment he receives. He tends to be a negativistic, defeated individual who requires considerable training and moral support. If the time is not taken to explain his problems to him, he probably will not follow his daily regime consistently and persistently.

During hospitalization, a primer explaining all the phases of treatment and containing a simple explanation of the disease processes is given to the patient. Each step is discussed, and the importance of daily application of each phase of treatment is emphasized, since it is often difficult to obtain cooperation of the patient without this orientation. Diaphragmatic exercises and rotary postural drainage are explained and practiced with the patient. Since many of these individuals give a history of smoking two or three packages of cigarettes daily, the avoidance of smoking is stressed, since it tends to augment bronchiolar spasm. Abdominal inflation belts are fitted, when indicated. Pneumoperitoneum is useful in certain instances and has been adequately discussed in the literature.

* * *

Summary

Successful results in treating patients with chronic pulmonary insufficiency can be effected through a combination of several procedures directed at correcting the existing pathologic conditions.

1). Relief of bronchial spasm and promotion of bronchial dilatation.

2). Removal of secretions and bronchial plugs by the simple procedure of rotary postural drainage and detergents.

3). Control of infection.

4). Oxygen therapy.

5). Careful training of the patient and correction of anatomical defects.

We have found that the patient who understands the reasons for therapy, especially rotary postural drainage, usually will carry out treatment with meticulous care, and, thus, he is able to maintain improvement. Careful training of the patient is extremely important, if improvement is to be expected.

REFERENCES

1. Arnold, W. O., and Carabasi, R. J.: The Management of Chronic Pulmonary Insufficiency, J. Arkansas Med. Soc. 49:98-101, Nov. 1952.
2. Arnold, W. O., and Carabasi, R. J.: Evaluation and Treatment of Chronic Pulmonary Disease, Writings and Reports from the Scott and White Clinic 1:8-13, April, 1953.
3. Baldwin, E. DeF., et al.: Pulmonary Insufficiency; Study of 122 Cases of Chronic Pulmonary Emphysema, Medicine 28:201-237, May, 1949.
4. Barach, A. L., and Swenson, P.: Effect of Breathing Gases under Positive Pressure on Lumens of Small and Medium Sized Bronchi, Arch. Int. Med. 63:946-948, May, 1939.
5. Barach, A. L., and Molomut, N.: An Oxygen Mask Metered for Positive Pressure, Ann. Int. Med. 17:820-821, Nov., 1942.
6. Barach, A. L.: cited by Bickerman, H. A., and Beck, G. J.: Physiological Factors in the Treatment of Chronic Hypertrophic Pulmonary Emphysema. Ann. Int. Med. 36:607-624, Feb., 1952.
7. Comroe, Julius H., Jr., and Dripps, Robert D.: **The Physiological Basis for Oxygen Therapy**, Springfield, Charles C. Thomas, 1950.
8. Drinker, C. K.: **Pulmonary Edema and Inflammation**, Cambridge, Harvard University Press, 1945, pp. 8, 29.
9. Goodman, L., and Gilman, A.: **The Pharmacological Basis of Therapeutics**, New York, The Macmillan Company, 1941, p. 817.
10. Harvey, R. M., et al.: Influence of Chronic Pulmonary Disease on Heart and Circulation, Am. J. Med. 10-719-738, June, 1951.
11. Motley, H. L., Lang, L. P., and Gordon, B.: Use of Intermittent Positive Pressure Breathing Combined with Nebulization in Pulmonary Disease, Am. J. Med. 5:853-856, Dec. 1948.
12. Riley, R. L.: Pulmonary Gas Exchange, Am. J. Med. 10:210-220, Feb. 1951.
13. Segal, Maurice S., and Dulfano, M. J.: **Chronic Pulmonary Emphysema**, New York, Grune and Stratton, 1953.
14. West, J. R., et al.: Physiopathologic Aspects of Chronic Pulmonary Emphysema, Am. J. Med. 10:481-496, April, 1951.

LATE POST-PARTUM BLEEDING

By EUGENE T. ELLISON, M.D. and WILLIAM D. THORNTON, M.D.*
Texarkana, Arkansas

Late post-partum bleeding in excess of that amount which would be expected at the time of the re-occurrence of menstrual function, sometimes presents a disturbing problem. There has been a tendency in the past for physicians to consider this excessive bleeding to be due to retained placental fragments, to sub-involution of the uterus to infections, or to delayed healing of injuries incurred at childbirth. This excessive bleeding comes at a time when the young mother is re-adjusting her life after the many months of partial disability from pregnancy and childbirth.

The time of the first menstrual flow after childbirth, occurs from six to ten weeks in the 85% of private patients who do not nurse their babies.[1] Thus, it occurs at a time when the uterus has had a very meager period of involution before being subject to ovarian stimulation. It is therefore, not unreasonable that there should be a considerable amount of trouble with this return of menstrual function. The study of the problem of late post-partum bleeding has received comment in the British literature, where several authors have stated that the first menstruation occurs without ovulation and is not therefore a true menstruation.[2, 3] Our literature has placed considerable emphasis lately, on immediate post-partum bleeding of severe nature, with incrimmination of factors of blood clotting as a pre-disposing factor in some cases.[4] However, these reports have usually been within the first two weeks after childbirth, rather than the late period with which we are primarily concerned here. At the recent Academy of Obstetrics and Gynecology meeting, emphasis was placed on the nutritional state of the post-partum period, suggesting that the stage of reproductive life had been neglected.[5]

Our observations on excessive bleeding at the time of the recurrence of menstruation goes back over a number of years and encompasses some 3,000 deliveries done in private practice. Some 50 cases or 0.6% have been severe enough to require careful study and active treatment, which has led to the crystallization of a therapeutic approach to this problem.

Patients universally present themselves to physicians at six weeks for a final check-up. Experience in our offices has indicated that the introduction to the case usually comes with a phone call, either shortly before or shortly after the six-weeks check-up, in which the patient states that, "she is bleeding more than she should," and the bleeding is often alarming. Review of these 50 cases has indicated that the majority fall in the period of 4 to 10 weeks, post-partum, but there was an occasional case up to four months. These patients when presenting themselves for examination usually have no temperature, are anemic, present no local tenderness and the majority of them had already stopped nursing for some time. The majority of these cases had received stilbesterol in small amounts during the first week to ten days after the baby was born, but had had no stilbesterol or testosterone for over two weeks and had not suffered re-occurrence of breast engorgement. Two of the cases were still nursing part time. None of the cases had had excessive temperature elevations during their short hospital stay after the delivery of the baby. On pelvic examination; there is usually bright blood in the vagina as well as on the pad under the patient. The uterus is soft, boggy, two to three times its normal size, often retroverted, and the cervix is soft and not completely closed. There is no odor to the discharge or other evidence of acute or chronic infection of the pelvic viscera. Physicians often treat such patients with hormones, hematinics and bedrest at home, because of the patient's desires, or the physicians do not wish to cause alarm to the patient's family by re-hospitalization. Our experience has been that much more active type of treatment is indicated and leads to a more rapid rehabilitation of these patients.

Treatment has consisted of immediate curettement with a sharp curette and the use of a Smith-Hodge pessary, if needed, transfusions in extreme cases, and antibiotics as a pre-cautionary measure. Out of the 50 cases curetted at this stage of post-partum life, the pathological material for this paper was obtained. Hospital re-admission did not exceed 48 hours in any of these cases. Recently some of these procedures have been done in the office, thus avoiding the expense of hospitalization. Their recovery is excellent and there is practically no delay in their rehabilitation to normal life.

The material obtained by curettement is bluish-brownish in color and most abundant, suggesting that it constituted a lining of the entire uterus of about one-fourth to a third of an inch in thickness.

* Read before the Seventy-eighth Annual Session Arkansas Medical Society, Fort Smith, April 20, 1954.

It resembles grossly, tissue removed from patients who were suffering from anovulatory bleeding or endometrial hyperplasia. The tissue virtually boils out at the time of curettement, is not in lumps, but constitutes a rather generalized lining of the entire uterus. The microscopic appearance of this tissue presents a thick sheet of endometrium from the basal layers to the superficial structures with the glands of the small type seen prior to ovulation in the non-puerperal state. This is, of course, the estrogenic phase. The stroma is active and healthy in appearance, but near the surface layers, there are in most cases, a large number of leukocytes and red corpuscles which give the tissue its brownish color when seen grossly. Whether this leukocytic infiltration represents true infection or is simply an exaggeration of cellular infiltration characteristic of hyperplasia is not entirely clear. In only three cases were there placental villi or other evidence of retained placenta seen. Even in these cases the bleeding seemed to be occurring from the thickly overgrown endometrium rather than from inflammatory areas around retained placenta.

Following curettement, these patients rapidly return to a normal life, felt better and in no cases had a recurrence of the excessive bleeding. The uterus shrank down rapidly and the patients had no further trouble. There is, of course, an occasional case where a large piece of placenta is found at this stage of the puerperium, but these cases of bleeding from endometrium as described above certainly out number these other cases by a large majority.

These patients described above, when treated in the office or in the hospital have had the ordinary laboratory procedures of a routine hospital admission and for the last several years have had fibrinogen determinations as well. Bleeding and clotting times have not been increased and the fibrinogen level has been within the limits of normal. Anemia, however, is a fairly frequent finding. There was no flare-up of puerperal fever following any of these procedures. Uterine cultures were regretfully not made.

Summary

It is our general conclusion that this excessive bleeding in the late post-partum period represents a menstrual phenomena associated with the early return of ovarian function which is of a pathological nature and does not represent a true subinvolution of the uterus or infection. The condition in its final analysis, resembles the anovulatory bleeding or endometrial hyperplasia seen in patients in the non-puerperal state. We believe, that this infrequently but disturbing complication of the late puerperal stage, should be used as a reason for emphasizing the necessity of patients attempting lactation for at least two or three months. The uterus and ovaries remain relatively in-active during lactation, and thus, allows the patients to completely recover from childbirth before menstruation which is re-established. To me, this is a real indication for nursing, for the sake of the mother which is entirely different from the indications layed down by pediatricians for the care of the new born.

As a final digression, I would like to encourage the members of our society to corollate material from their private practice and offer it to our society for presentation. Such material as has been presented above is more easily obtained by the physician in private practice than those doing primarily institution or teaching work. It is a sample of a problem which is more clearly seen by the many practitioners, and its solution in many cases, may be one only of corollation of data and presentation and can be of considerable value to other men working in this field.

REFERENCES

1. Albert Sharman, M.D., Fertility and Sterility, Vol. 11, P:371, September, 1951.
2. Albert Sharman, M.D., Journal of Obstetrics and Gynecology, British Empire Volume 58, P:440, June, 1951.
3. Edwin J. DeCosta, M.D., Milton S. Mark, M.D., and Ralph K. Reis, M.D., GP. Vol. 11, P:47, May, 1951.
4. W. T. Thompkins, et al., Vol: To be published.
5. Massive Post Partum Hemorrhage, Robert K. Noland, M.D., and Paul G. Frick, M.D., Obstetrics and Gynecology, Vol. 11, P:508.

REPORT OF THE SAN FRANCISCO AMA MEETING

R. B. ROBINS, M.D., Delegate

The American Medical Association held its 103rd Annual Meeting in San Francisco June 21-25, 1954. Dr. Walter B. Martin of Norfolk, Virginia, was installed as the new president. Dr. Elmer Hess of Erie, Pennsylvania, was elected president-elect. Dr. Clark Bailey of Harlan, Kentucky, was named vice-president. Dr. David B. Allman of Atlantic City and Dr. F. J. L. Blasingame of Wharton, Texas, were re-elected to their positions on the Board of Trustees. Also re-elected were Dr. George F. Lull of Chicago, secretary; Dr. J. J. Moore of Chicago, treasurer; Dr. James R. Reuling of Bayside, New York, as speaker of the House of Delegates, and Dr. Vincent Askey of Los Angeles, vice-speaker.

Dr. J. Morrison Hutcheson of Richmond, Virginia, was named by Dr. Martin as a member of the Judicial Council to succeed Dr. Edward R. Cuniffe of New York, who served as Council chairman for many years. Dr. Homer Pearson of Miami, Florida, was elected the new chairman. The Judicial Council is considered the Supreme Court in American medicine.

The next annual meeting will be held in Atlantic City June 6-10, 1955.

Fee splitting, osteopathy, closed panel medical care plans, veterans' medical care and training of foreign medical school graduates were among the major topics of discussion and action by the House of Delegates.

The House of Delegates resolved that it firmly opposes fee splitting, rebating or payment of commissions in any guise whatsoever, and that it further opposes any mechanism that encourages this practice. When two or more physicians actually and in person render service to one patient they should render separate bills. There are cases, however, where the patient may make a specific request to one of the physicians attending him that one bill be rendered for the entire services. Should this occur it is considered to be ethical if the physician from whom the bill is requested renders an itemized bill setting forth the services rendered by each physician and the fees charged. The amount of the fee charged should be paid directly to the individual physicians who rendered the services in question. Under no circumstances shall it be considered ethical for the physician to submit joint bills unless the patient specifically requests it and unless the services were actually rendered by the physicians as set out in the bill. Insurance companies must be encouraged to pay bills in separate checks to physicians also.

Several resolutions were introduced regarding the osteopathic problem. Final action was delayed until December, 1954.

The much-publicized New York resolution, calling for several changes in the Principles of Medical Ethics, relative to participation in closed panel medical care plans, was considered and it was recommended that the Judicial Council investigate the relations of physicians to prepaid medical care plans and render such interpretations of the Principles of Medical Ethics as the Council deems necessary and report to the House of Delegates not later than the next annual meeting of the Association.

Action was taken condemning the present practice of establishing service-connection for veterans' disabilities by legislative fiat. This is considered an unscientific method of determination of service-connection.

Action was taken terminating the "Seal of Acceptance" program for voluntary health insurance plans.

Action was taken calling for discontinuance of the registration of hospitals by the Council on Medical Education and Hospitals and suggesting that the Joint Commission on the Accreditation of Hospitals be requested to undertake the registration of hospitals in addition to its present accreditation program.

Among a variety of other actions the House of Delegates also: Voted to continue the holding of the annual mid-year Clinical Meetings;

Approved the establishment of a program of medical military scholarships with appropriate safeguards limiting the number of students involved;

Dr. William Wayne Babcock of Philadelphia was awarded the 1954 Distinguished Service Award of the American Medical Association for his outstanding contributions to medicine and humanity.

★ Editorial ★

Newspaper coverage has kept the public well informed on the steps being taken in establishing the Perry County test project for private medicine.

As of the middle of July, a building had been selected and a local drive for funds to remodel it for use as a one-doctor clinic, was well under way. A board of local advisors was selected and a committee from the Arkansas Medical Society served as advisors to Dean Hayden C. Nicholson to the project. We believe these are sound fundamentals.

There are other similar experiments now being conducted in other areas, none of which have exactly these fundamentals. A few communities in Maine have conducted experiments in providing office-clinic accommodations and furnishing suitable living quarters to induce physicians to come and these have had varying degrees of success.

Two essential differences make the Perryville project distinct. One is the use of the office facility to make a statistical study during the first two years by the operators of the project. The study would seek to learn of the needs and possibilities of making health care available to sparsely settled communities. Some pertinent information may well be gained from such a study.

The other unique feature is the stipulation that the physician must not be subsidized and that it not be held up as an **easy** way to develop a private practice. The physician selected for the place will have to understand that his results are his own responsibility and that he, as any other physician, must keep the initiative, the freedom from regulation that should be the prerogative of every physician, and that he must develop with his plan or go down with it. These things are all for the good of the physician and for the good of the health of the people of Perry County. Mr. Winthrop Rockefeller's contribution, which made the test project possible, wisely stipulated that the project should stand on its own feet and that ways be found for health service to be made available to rural groups in such manner as to maintain the freedom of the physician from government largesse and the establishment of a competent medical service that could be successfully maintained by the people who are served. These are the good old fashioned American ways of doing things.

The Council went on record in June as reminding members that in making public appearances, they are to be guided by the code of ethics of the American Medical Association. Attention is invited to that section governing personal appearances of physicians on the programs of cults, psuedo-scientific societies and trades.

LETTERS

Honorable J. W. Fulbright
Senate Office Building
Washington, D. C.

Arkansas physicians supported some of the legislation that affects us, as the Hill-Burton Expansion, but we feel that further loans as in HR 7700 are needless and expensive to government and can be done at local levels. We also feel that the Re-insurance Program HR 8356 is entirely unnecessary and will impede progress already made by Blue Cross and others. Both these bills are now under House consideration, and we hope that you oppose them when they come up for Senate conference and action. Best personal regards.

This letter, with others, went to Senator Fulbright early in July. We feel the Senator is desirous of knowing what stand is taken by the great majority of Arkansas physicians.

SPECIAL

To Members of the Bowie-Miller Medical Society:

There are so many things happening in regard to medicine and the members of the profession, in Washington, that I feel every one should have the benefit of seeing the Washington Letters which come to the Councilor. Your officers are taking the authority to have these reprinted and mailed to you, and if you wish them to continue, you can so indicate by your vote at the next medical meeting.

Respectfully,
(S).....
Harry E. Murry, M.D.,
Councilor Sixth District.

(ED. NOTE): Councilor Murry is keeping his membership up-to-date. If the reprints are reaching the membership in time to let effective work be done with our Congressional Delegation in Washington—Power to him.

COMING MEETINGS

Annual Fall Assembly Arkansas Academy of General Practice, October 6-7, Little Rock.

Southern Medical Association, November 8-11, 1954, St. Louis.

Some day physicians will learn that public relations can't be bought with money, but must be distilled into the heart of the patient at the bedside.

NEW PROFESSOR OF MEDICINE

RICHARD V. EBERT

Hayden C. Nicholson, Dean of the School of Medicine and Provost for Medical Affairs has announced the appointment of Dr. Richard V. Ebert as Professor and Head of the Department of Medicine of the School of Medicine. This professorship has been vacant since the resignation of B. B. Wells in the summer of 1953, and James T. Wortham has been acting head of the department during this interim.

Dr. Ebert at the present time is professor of medicine at Northwestern University Medical School and chief of the Medical Service at the Veterans Administration Research Hospital in Chicago.

Dr. Ebert received his undergraduate training at the University of Chicago and his medical training at the University of Chicago Medical School. He received postgraduate training at Harvard Medical School. He is certified by the American Board of Internal Medicine, and is a fellow of the American College of Physicians.

He is a member of the Editorial Board, **Journal of Clinical Investigation.** Dr. Ebert served in the Army Medical Corps during World War II, with most of his tour of duty being spent in the European Theater. He will assume his duties here at the School of Medicine later in the summer.

GOVERNOR'S CONFERENCE

Reports from the meeting of state's governors at Bolton Landing, New York, in mid-July are encouraging. Republican Governor J. Bracken Lee of Utah says it's time for the Federals to abolish income taxes so the states can have some share in the government of its people. We would say Governor Lee is following in a fine tradition of Lees—Lees fought against Federal encroachment of States Rights in an earlier century. We are glad to see the "cause" of General Robert E. Lee so actively and widely supported.

With the single exception of the governor of New Jersey, every governor at the conference indicated that the Federals were taking too much power and are trying now to take over road planning. All resisted and resented Vice-President Nixon's talk on more power (via roads) in Washington.

PUBLIC Physician Patient Personal RELATIONS

WEST VIRGINIA STATE MEDICAL ASSOCIATION

THE DOCTOR AND HIS COMMUNITY

Does your community have medical representation at meetings of groups interested in health and welfare? Doctors must help solve the local problems of the indigent, the aged, and many others. Strict medical care is no longer enough. Free clinics and charity patients are not enough. Some time must be allotted to citizenship.

Doctors must assume community responsibilities on an every day, part-of-the-group basis. The daily and weekly influence of a doctor upon health policies is of the greatest value to a community (such influence cannot be purchased; when you let Joe do it, he does it Joe's way). The medical profession has an obligation to furnish leadership in health matters. Doctors must again become leaders instead of being led.

Lacking time for citizenship
the chance for a solution of problems
may be taken from us.

Refusing these responsibilities,
we have no right to criticize foreign and
exotic policies of health and welfare

OBITUARY

JOSEPH PETER BREMER, 68, of Point Cedar, died June 12 in a Hot Springs hospital. He had practiced medicine in the Point Cedar area for 30 years.

He was a member of the Point Cedar Methodist Church and a member of its board of stewards. He was a Mason.

He had been a member of his County Medical Society and the Arkansas Medical Society for many years.

Survivors include his wife, Mrs. Viola Bremer. Funeral services were held June 14 at the Point Cedar Methodist Church with the Rev. John Newell of Russellville, assisted by the Rev. Connie Robbins of Amity, officiating. Burial was in Weslyean Cemetery.

C. B. CAPEL, 69, prominent Pine Bluff physician and surgeon, died in Little Rock June 12.

A native of Grant County, Dr. Capel was born on July 22, 1884. He was the son of the late John B. and Elizabeth Jane Capel.

Dr. Capel received his education in the schools of Grant County and attended the University of Arkansas Medical School.

He came to Pine Bluff 31 years ago and in recent years, operated a clinic on West Second Avenue with his son, H. T. Capel.

He was a member of the staff on the Davis Hospital, the Jeffeson County Medical Society, the Arkansas Medical Society, the Grapevine Masonic Lodge, the Little Rock Consistory, the Sahara Shrine Temple and the Lakeside Methodist Church.

Survivors include his wife, the former Viola Henry; a daughter, Mrs. Kenneth Kesterson of Pine Bluff; two sons, Dr. H. T. Capel and Homer B. Capel, both of Pine Bluff; a brother, Jim Capel of Sheridan; two sisters, Mrs. Fannie Tabor and Mrs. Addie Green, both of Little Rock; one granddaughter and five grandsons.

OSSIAN HOMER KING, 67, Hot Springs, died June 14 in a Little Rock hospital. Services were conducted at the First Presbyterian Church in Hot Springs.

Dr. King, a native of Louisiana, was reared in Little Rock and graduated from the University of Arkansas Medical School. After internship at an Indiana hospital, he practiced in Hot Springs as an ear, eye and nose specialist.

Dr. King was past president of the Garland Medical Society and a member of the Arkansas and American Medical Associations. He was a member of the First Presbyterian Church of Hot Springs and past president of the Kiwanis Club.

He is survived by his widow, Hot Springs; a sister, Mrs. R. C. Means, and two brothers, the Rev. W. Dawson King and C. Mack King, all of Little Rock.

Burial was at Roselawn Cemetery in Little Rock.

W. E. JONES, 40, Texarkana, died July 3, of carbon monoxide poisoning, near his home. He was a member of the Texas Medical Society and was an assistant professor of medicine in the University of Arkansas School of Medicine. He served two years in the CBI theater during World War II, locating in Texarkana in 1946.

He is survived by a wife and four children. Burial was in Hillcrest Cemetery, Texarkana.

Arkansas TRAVELING

And Clipping Bits Here and There

It seems apparent that the general practitioner is going to be involved in the actual treatment of the tuberculosis patient to a much greater extent than he has in the recent past and fewer patients will be treated by specialists in chest diseases. Another factor acting in the same direction is the relatively shorter time that the average patient will spend in a hospital and the fact that such hospitalization is less likely to be in a remote institution. The family physician, therefore, will be less likely to lose supervision of his patient. This trend requires a change in the nature and emphasis of postgraduate medical conferences and courses of instruction, which must be directed more toward the general practitioner.

James E. Perkins, M.D.,
NTA Bulletin, May, 1954.

PROCEEDINGS OF SOCIETIES

The regular monthly meeting of the **Sebastian County Medical Society** was held at the Health Center on June 8.

Hoyt Kirkpatrick was in charge of the program which was on the problem of the frozen shoulder.

James B. Thompson.

The **Arkansas Radiological Society** met June 25, 1954, at Little Rock.

A social period and dinner were enjoyed before the meeting with Ed Gray, Joe Calhoun, and Joe Scruggs as hosts. After a moment of silent tribute to the memory of D. A. Rhinehart the group participated in a lively and interesting business session, directed by George Burton, El Dorado. This was followed by a stimulating film reading session, moderated by I. Meschan of Little Rock.

New officers for the Society were elected as follows:

President.....George Burton, El Dorado
Vice-President.....Edwin F. Gray, Little Rock
Secretary-Treasurer.....Joe A. Norton, Little Rock
Executive Committee Member
3-year term.....Cyrus P. Klein, Texarkana
Executive Committee Member
2-year term.....Ernest A. Mendelsohn, Ft. Smith
Executive Committee Member
1-year term.....Charles W. Anderson, Pine Bluff
Councilor to American College of
Radiology.....Cyrus P. Klein, Texarkana

Joe A. Norton, Secretary.

Elmer Purcell, assistant professor of medicine at University of Arkansas, was guest speaker at the meeting of the **Pope-Yell County Medical Society** held at St. Mary's Hospital, Thursday, July 8, 1954.

W. E. King, Secretary.

UNIVERSITY OF ARKANSAS GRADUATION

Degrees were awarded to 103 students of the University of Arkansas Schools of Medicine and Pharmacy June 14 at commencement exercises at the Auditorium, Little Rock.

Dr. Jacques P. Gray of Detroit, director of special medical services at Parke, Davis & Co., was the commencement speaker.

Seventy-two of the graduates received doctor of medicine degrees. Thirteen received bachelor of science degrees in medicine and two received bachelor of science degrees in medical technology. The School of Pharmacy awarded bachelor of science degrees to 16 students.

The graduates were urged to conduct an "honest and severe self-appraisal of personal qualifications—liabilities as well as assets."

Dr. Gray also asked the graduates to "embrace five concepts as part of your being and everyday living."

He said they are: never flaunt your professional status; continue your quest for knowledge; be proud of your profession, but embrace the modesty and humility of the scientist; improve communications; and hold fast to your ideals and principles.

"The rewards come," Dr. Gray emphasized, "in gaining the status and stature of a very important person, not only as a member of the Health Service Team, but also as a mighty important citizen in your community.

"Then you will be the recipient from those whom you serve of their Respect, Reliance, and Responsiveness—all of which are among life's greatest and most satisfying values due you for a job well-done."

PERSONALS AND NEWS ITEMS

Registered at the AMA convention in San Francisco in June: Eli Gary, Arkadelphia; J. S. Levy, Little Rock; Rufus B. Robins, Camden; Robert W. Talley, Little Rock; W. R. Brooksher, Fort Smith; Hoyt L. Choate, Little Rock; Benjamin B. Wells, Omaha; O. L. Cancilla, Columbus; A. T. DePalma, Fayetteville; W. E. Knight, Fort Smith; Gardner H. Landers, El Dorado; Henry W. Thomas, Dermott; Willis E. Brown, Little Rock; Bernard Capes, West Helena; E. H. Crawfis, Little Rock; James L. Jackson, Bentonville; Frederick H. Jones, Piggott; K. G. Jones, Little Rock; Howard U. Monroe, Valmar; Henry Bachman, Malta; Eva Dodge, Little Rock; Davis W. Goldstein, Fort Smith; Ross E. Maynard, Pine Bluff; Lowry H. McDaniel, Tyronza; George Potter, Camp Chaffee; Louise M. Henry, Fort Smith; Joseph P. Hickey, Little Rock.

Congratulations to Mrs. Wilbur G. Lawson (our Mona) on being elevated to President-elect of the Women's Auxiliary to the AMA at their June meeting in San Francisco. The charming Mrs. Lawson will take office as head of that body next May in Atlantic City, New Jersey.

Anderson Nettleship, Little Rock, participated in the special exhibit on Fresh Pathology at the recent AMA convention in San Francisco. Visitors reported these Fresh Pathology exhibits as most popular.

Willis E. Brown, Little Rock, was a member of a panel discussion on Perinatal Mortality held in San Francisco during the recent American Medical Association meeting there.

Trinity Hospital and Clinic, Little Rock, has closed and offered for sale. This closes a partnership privately-owned hospital which opened in 1919. O. K. Judd, the only one of the original partners moved his office about June 1 to his home, and was the last to leave the building. Its closure brings to an end a chapter in medical economics filled with controversy, which reached its peak in the depresssion days of 1929-1934. It is perhaps better that those turbulent days can be forgotten, as the building goes to other uses.

C. C. Long, Ozark, Secretary of the Arkansas Academy of General Practice, has a few extra copies of April Newsletter, containing a list of "average fees" charged by Arkansas physicians. The study was made last January by the Academy. Anyone interested in a copy, write him.

Guy V. Robinson has opened a new Clinic Building on South Elm at Dumas.

Ralph Joseph, Walnut Ridge, received orders for duty with the Army in July. He holds a captain's commission and has been assigned to Brook Army Medical Center in San Antonio, Texas. Orval Riggs will take over the operation of the Joseph Clinic. Riggs is returning to his home town from a residency in St. Louis.

Joseph L. Rosenzweig has returned from the armed services and opened his office in Hot Springs.

The medical staff of the Clark County Memorial Hospital is sponsoring more young women for entrance into nurses training schools and are providing scholarships for properly qualified applicants. The program started a few years ago and has gained momentum. That this is a worth while project need not be called to the attention of Arkansas physicians.

Wayne P. Jones opened an office at the Allen Hospital, Batesville, after completing an internship in St. Joseph, Missouri.

W. T. Holman announces the opening of his offices for the practice of general medicine and surgery at Fort Smith.

The Solon Hodge Post of the American Legion elected W. L. Newton, Smacker, as post surgeon for the coming year.

Lee Dean, Rogers, is post surgeon of the Batjet Post of the American Legion in that city.

The Walker-Wilson Post of the American Legion elected Ross Van Pelt as post surgeon in Eureka Springs.

C. P. Arnold, Prescott, was recently elected post surgeon of the Hooker-Nelson Post 57 American Legion.

Numbers of towns in Arkansas are looking for physicians. The latest coming to our attention is Van Buren, whose Lions Club has taken as a project the interesting of a physician who will help serve Van Buren and Crawford County.

L. H. McDaniel was elected chairman of the Section on General Practice in the American Medical Association in San Francisco in June.

The AMA is producing a new series of public relations leaflets for distribution through State Medical Societies. They are brief, colorful, and designed to convey an important health message to the public. Requests for these pamphlets should be made to the Arkansas Medical Society, Kelley Building, Fort Smith.

The pamphlets are:

Quack!—Outlines the dangers of going to a quack healer for medical treatment;

Health Today—Summarizes the progress made by medicine in the past 50 years;

Why Wait?—Recommends the best way to select a family doctor; and

On Guard!—Tells of the steps taken by the AMA to evaluate drugs in the public interest.

James W. Marsh, Warren, is moving into his new office building on North Main Street later this summer.

An iron lung has been made available for the Boone County Hospital, Harrison, through the efforts of the Harrison Lion's Club and Mr. Ralph Dunkel, who made the contribution.

Frank M. Adams, Hot Springs National Park, has moved his office from Wade Clinic to 605 Medical Arts Building.

Robert T. Cook, Clarendon, has moved to Stuttgart and will be associated there with W. R. Champion and E. A. McCracken in general practice.

Arkansas' Negro physicians are active supporters of the Arkansas Medical, Dental, and Pharmaceutical Association and the 61st annual session was held in June in Little Rock. At this meeting, their speakers included: H. King Wade, Jr., Hot Springs; Willis E. Brown, Little Rock; and Katherine Dodd, Little Rock.

James Barker, E. Clark Gillespie, and Clarence G. Sutherland, members of the University of Arkansas School of Medicine faculty, were certified as diplomates of the American Board of Obstetrics and Gynecology last month.

Jeff J. Baggett, Prairie Grove, spent a two-weeks vacation at his cabin on Ten-Killer Lake in July.

Fredrick F. Ferguson, Little Rock, epidemiologist with the U. S. Public Health Service, is leaving for Puerto Rico where he will undertake a two-year study in Parisitology, chiefly in the field of filiariosis and schistosomiasis. He will maintain his permanent residence in Arkansas.

Robert T. Bryan, Jr., Little Rock, has accepted a year's fellowship from the American Cancer Society. His research will be done in the Francis Delafield Hospital in New York.

C. Lynn Harris, Bradford, has opened an office in Hope.

H. Blake Crow has opened his offices at 112 East Calhoun Street, Magnolia. He is in general practice.

L. H. Turney, Prescott, will be associated with Glenn Hairston in the new remodeled Prescott Clinic after July 1st.

David S. LeVine and Bascom P. Rainey have opened offices at 128 S. Main Street, Jonesboro. Both are general practitioners.

William King Jordan, Little Rock, head of the Department of Neurology at the School of Medicine took part in the International Neurochemical Symposium held in Oxford University, England, during the month of July.

Marion S. Craig, Jr., Little Rock, with Mrs. Craig, spent a vacation in California, Utah, and Colorado, following the American Proctologic Society Meeting in Los Angeles in June.

Contributions to the American Medical Education Foundation from the state of Arkansas during the months of May and June, 1954: Woman's Auxiliary to the Arkansas Medical Society; R. H. Chappell, Wadley Bldg., Texarkana; Hugh R. Edwards, Searcy; J. H. McCurry, Cash.

George G. Regnier, Little Rock, has announced his association with William J. Rhinehart and Joe A. Norton in the practice of Radiology.

Hal R. Black, Jr., has joined H. Fay H. Jones in the Jones-Black Urology Clinic in Little Rock.

TUBERCULOSIS ABSTRACTS

A Review for Physicians

ISSUED MONTHLY BY THE NATIONAL TUBERCULOSIS ASSOCIATION

TUBERCULOSIS IN CHILDREN

By EDITH M. LINCOLN, M. D.

NTA Bulletin, March, 1954

Chemotherapy has been very useful in reducing the death rate from first infection, often called primary tuberculosis, in children. In many sections of the United States the death rate in children has always been low. Because good control of tuberculosis in adults has been established, there are relatively few active cases and consequently, few children are infected.

The effect of chemotherapy can best be judged in areas where formerly the death rate in children was high. Such a situation is found in the chest clinic of the Children's Medical Service of Bellevue Hospital, a large municipal hospital in New York City. Patients on this service come mainly from families of very low economic level, frequently receiving public assistance, and living in crowded conditions.

Twenty years ago one of every five children admitted to the tuberculosis ward of Bellevue Hospital died of the disease, usually within a year. Most of these children were first diagnosed in the hospital because a tuberculin test was part of the examination on admission. Of those who were admitted with the diagnosis of tuberculosis the great majority had originally been found by contact examinations or by tuberculin tests. The death rate in tuberculous children was unchanged until streptomycin became available late in 1946.

In tuberculous meningitis, which caused 60 per cent of the deaths from primary tuberculosis, the case fatality rate fell to 32 per cent between 1947 and 1951 after chemotherapy was employed. When isonicotinic acid derivatives were introduced in 1952, the case fatality rate was lowered to about 12 per cent. Before chemotherapy tuberculous meningitis was 100 per cent fatal.

The use of antimicrobial therapy in other serious forms of tuberculosis has been even more effective. Since January 1, 1947, only one child at Bellevue Hospital has died of miliary tuberculosis, which until then was almost 100 per cent fatal, disease. Thus, in one hospital the case fatality rate from primary tuberculosis and its complications fell from over 20 per cent to 5.0 per cent after streptomycin and to 1.5 per cent after the introduction of isoniazid.

But mere survival is not enough. The great majority of the survivors from meningitis, after long convalescence, are leading normal lives, but a few show remains of the disease in partially paralyzed limbs or in diminished mental capacity. Such poor results seem to occur most often when the meningitis is not diagnosed and treated in an early stage. No one form of treatment will ensure complete recovery from tuberculous meningitis. The most important factors in success would seem to be an awareness of the possibility of tuberculosis and the recognition of the need for vigorous and prolonged therapy. A child with tuberculous meningitis diagnosed late is more likely to die, and if he recovers, is more likely to show evidence of damage due to the disease.

The importance of early diagnosis and prolonged treatment applies equally well to other forms of tuberculosis. A small cavity within a locally progressive primary tuberculosis of the lung without much evidence of pulmonary spread on X-ray will often heal under chemotherapy and remain well. On the other hand, chemotherapy may save the life of a child with more extensive disease but at a later date surgery becomes necessary because a cavity or extensive scarring persists. Even when a complete cure is obtained the child has undergone years of hospital care which might have been avoided by earlier diagnosis of the pulmonary tuberculosis.

Chemotherapy is useful in other complications of primary tuberculosis. Sometimes in tuberculous disease of the bones or glands a sinus has been formed causing drainage through the skin. In such cases almost magical results have been seen with specific therapy, with prompt closing of the sinus, often permitting surgery which would

have been impossible without chemotherapy. In and only one baby died of tuberculous disease of the lung caused by local spread from the primary tuberculosis of the intestines the symptoms disappear quickly when the patient receives antimicrobial therapy. Many other forms of tuberculosis are also cured by appropriate chemotherapy.

In other complications of primary tuberculosis, such as disease of the bones, or of the lymph glands, it is hard to evaluate the results of chemotherapy, since such forms tend to be chronic and even without treatment have periods of spontaneous remission. Here again, when the complication is diagnosed before extensive damage is done, cure by chemotherapy or conservative treatment or both often results, whereas in late cases surgery is often required. In some forms of primary tuberculosis, notably in disease of the bronchi or endobronchial tuberculosis, so common in infants and young children, no form of chemotherapy so far devised has appeared to either alleviate symptoms or shorten the course of the disease.

No child should be operated on for a tuberculous complication without receiving chemotherapy during the period of surgery and for a few weeks thereafter. Indeed it may be said that because of the danger of spread of the tuberculous disease, no child with active tuberculosis should receive surgical treatment for any cause without coverage with antimicrobial therapy.

The question of the necessity for specific treatment of uncomplicated asymptomatic primary tuberculosis is still under discussion. There was no reason for treating such cases with streptomycin. With the advent of isoniazid we have a different story. While again there seems to be no clear proof that the disease at the portal of entry is affected for the better, no one has reported a case of clinical meningitis developing in a patient who was receiving isoniazid. This is true even in individuals treated for miliary tuberculosis, a form of tuberculosis in which the meningitis rate has been reported as high as 70 per cent. If these observations can be substantiated, the use of isoniazid must be considered in every child with active primary tuberculosis and possibly in those with recent conversion of tuberculin tests even if chest X-rays are negative. Moreover, it will be necessary to treat with isoniazid for at least a year since it is known that meningitis is most apt to occur during this period. This will be a tremendous task and we should be sure of our facts before undertaking it.

The right way to prove the usefulness of isoniazid in the prevention of meningitis would be to follow a series of children with primary tuberculosis in which some cases are treated for a year and a similar control group is not treated, the selection of cases for each group being made arbitrarily. Such a study is now under way in Bellevue Hospital. Since the incidence rate of meningitis in primary tuberculosis is unknown, a large number of cases may be necessary to decide this important question.

If tuberculous meningitis and other serious complications can be prevented by the wider use of antimicrobial therapy, it will be a great step forward. But it will not eliminate the need for early diagnosis of every child infected with tubercle bacilli before complications occur. Widespread use of the tuberculin test in schools and hospitals and by private physicians is needed in order to promote early diagnosis of tuberculosis and augment the usefulness of chemotherapy in prevention as well as treatment.

BOOK REVIEWS

A.M.A. Fundamentals of Anesthesia: Prepared under the Editorial Direction of the Consultant Committee for Revision of Fundamentals of Anesthesia, a publication of the Council on Pharmacy and Chemistry of the American Medical Association. 3rd Ed. 1954. W. B. Saunders, Philadelphia. 279 pp. Price $6.00.

This third edition of one of medicine's best sellers is revised under the direction of a consultant committee of the Council of Pharmacy and Chemistry of the American Medical Association. It is a compendium of outstanding authors and is edited almost to the point of being cryptic, and is published almost in outline form. This form makes it an easy reference to a specific anesthetic problem, of whatever nature and is an excellent text for the intern or resident.

For the first 50 pages, the reader is given the latest concepts of the physiology of the respiration and it's chemistry and physics and of important preoperative considerations. Then there are three long and complete chapters on General Anesthesia, Regional Anesthesia, and Special Anesthesia. These are followed by chapters on post-operative care and complications and inhalation therapy in general.

Techniques are presented in 1-2-3 form, and special techniques for cesarean section and for combined inhalation and chemical anesthesia. This text is highly complete and is a quick reference for the surgeon or obstetrician as well as a genuine source of information for the anesthetist.

The Atom Story: J. G. Feinburg: Foreword by Fredrick Soddy. 243 pages. Philosophical Library, Inc., New York. $4.75.

Written expressly for the lay reader this book has the charm of the story teller to whom no holds are barred and everything is explained so easily and simply that one gets the impression it is written by Pollyanna under a nom de plume. The jerk back to reality comes when one is warned of the dangers of atomic attack and quotations from the Civil Defense pamphlets issued by the U. S. Government.

ARKANSAS MEDICAL SOCIETY COMMITTEES FOR 1954

Term Expires April *

COMMITTEE ON CANCER CONTROL

C. A. Archer, Jr., Conway, Chairman ... 1957
Edwin F. Gray, Donaghey Bldg., Little Rock ... 1956
W. H. Handley, Jr., 426 N. Washington, El Dorado ... 1956
W. E. Jennings, Rogers ... 1957
Fred Krock, 1500 Dodson, Fort Smith ... 1957
N. W. Peacock, Ashdown ... 1955
H. H. Atkinson, Fordyce ... 1955

COMMITTEE ON MEDICAL LEGISLATION

Joe Shuffield, Donaghey Bldg., Little Rock, Chairman ... 1957
Fount Richardson, 316 West Dickson, Fayetteville ... 1957
Jean Gladden, Harrison ... 1957
L. H. McDaniel, Tyronza ... 1957
T. S. Van Duyn, Stuttgart ... 1956
H. A. Causey, Pine Bluff ... 1956
H. King Wade, Sr., 231 Central, Hot Springs ... 1956
Perry Dalton, Camden ... 1956
Roy I. Millard, Russellville ... 1955
J. B. Wharton, Jr., El Dorado ... 1955
Alan G. Cazort, 1425 West 7th, Little Rock ... 1955
Hoyt Allen, Donaghey Bldg., Little Rock ... 1955

COMMITTEE ON PUBLIC HEALTH

(Also to Serve as Rural Health Committee)

Ben N. Saltzman, Mountain Home, Chairman ... 1957
John B. Kirkley, Jonesboro ... 1955
Tasker N. Rodman, Leachville ... 1956
W. H. Pruitt, Camden ... 1957
Duane E. Brothers, Ozark ... 1956
John T. Herron, State Health Dept., Little Rock ... 1955
Robert Hyatt, Monticello ... 1955

Sub-Committee on Maternal and Child Welfare

Roger Bost, 222-A South 16th, Fort Smith, Chairman ... 1957
W. H. Pruitt, Camden ... 1955
E. H. Crawley, 1417 West 6th, Little Rock ... 1956

Sub-Committee on Industrial Health

H. E. Mobley, Morrilton, Chairman ... 1957
John D. Olson, 1500 Dodson, Fort Smith ... 1957
Charles A. Taylor, Batesville ... 1956
A. D. Cathey, El Dorado ... 1956
Samuel B. Thompson, Donaghey Bldg., Little Rock ... 1955
Frank Padberg, Donaghey Bldg., Little Rock ... 1955
Noble Daniel, 908 Pine, Texarkana ... 1956

COMMITTEE ON MEDICAL EDUCATION

H. W. Thomas, Dermott, Chairman ... 1957
James M. Kolb, Clarksville ... 1957
Jack Kennedy, Arkadelphia ... 1956
Rodger Dickinson, DeQueen ... 1956
C. C. Long, Ozark ... 1955
John Wm. Smith, 1415 West 6th, Little Rock ... 1955

COMMITTEE ON HOSPITALS

A. S. Koenig, First National Bank Bldg., Fort Smith, Chairman ... 1957
Willis Brown, 12th and McAlmont, Little Rock ... 1955
Guy Shrigley, Clarksville ... 1956
Jeff Baggett, Prairie Grove ... 1956
J. Max Roy, Forrest City ... 1957

COMMITTEE ON PUBLIC RELATIONS

Dale Alford, Meers Building, Little Rock, Chairman ... 1957
M. H. Harris, Newport ... 1955
Lewis Hyatt, Monticello ... 1957
L. E. Drewery, Camden ... 1956
W. T. Holman, Jr., 1102 East Main, Van Buren ... 1955
M. C. John, Jr., Stuttgart ... 1956

Sub-Committee on Liaison with Auxiliary

Charles R. Henry, Donaghey Bldg., Little Rock, Chairman ... 1955
Edwin F. Gray, Donaghey Bldg., Little Rock ... 1955
R. C. Dickinson, Horatio ... 1955
Roy I. Millard, Russellville ... 1955

Sub-Committee on State Health and Medical Resources for Civil Defense

Joseph A. Norton, Donaghey Bldg, Little Rock Chairman ... 1957
L. E. Drewery, Camden ... 1956
Joseph Buchman, Donaghey Bldg., Little Rock ... 1955

Representative to Nursing Profession

Hoyt Choate, 1120 Marshall, Little Rock ... 1955

COMMITTEE ON SCIENTIFIC PROGRAM FOR ANNUAL SESSION

Alfred Kahn, Jr., Donaghey Bldg., Little Rock, Chairman ... 1955
Charles R. Henry, Donaghey Bldg., Little Rock ... 1955
Frank Kumpuris, Waldon Building, Little Rock ... 1956
Joseph Norton, Donaghey Bldg., Little Rock ... 1957
Samuel B. Thompson, Donaghey Bldg., Little Rock ... 1956
Lawrence Zell, 715 East 13 Street, Little Rock ... 1957
Drew Agar, Donaghey Bldg., Little Rock ... 1955
Jerome Levy, 1425 West 7th, Little Rock ... 1955

COMMITTEE ON ARRANGEMENTS FOR ANNUAL SESSION

General Arrangements

H. King Wade, Jr., 231 Central, Hot Springs, Chairman ... 1955
H. King Wade, Sr., 231 Central, Hot Springs ... 1955
Frank M. Burton, Medical Arts Bldg., Hot Springs ... 1955
George B. Fletcher, Medical Arts Bldg., Hot Springs ... 1955
Leeman H. King, Medical Arts Bldg., Hot Springs ... 1955
Frank M. Adams, 231 Central, Hot Springs ... 1955
Colonel Charles Young, Army and Navy Hospital, Hot Springs ... 1955
L. G. Martin, Medical Arts Bldg., Hot Springs ... 1955

Registration

Joseph W. Leatherman, Medical Arts Bldg., Hot Springs, Chairman ... 1955
Jack Wright, Medical Arts Bldg., Hot Springs ... 1955
E. R. Browning, Thompson Bldg., Hot Springs ... 1955

Term Expires April *

Entertainment

John W. Dodson, Jr., Medical Arts Bldg., Hot Springs, Chairman 1955
R. H. Atkinson, Medical Arts Bldg., Hot Springs 1955
W. A. Goodrum, Medical Arts Bldg. Hot Springs 1955
George J. Fotioo, Medical Arts Bldg. Hot Springs 1955

Golf

Gaston A. Hebert, Medical Arts Bldg., Hot Springs, Chairman 1955
Driver Rowland, Medical Arts Bldg., Hot Springs 1955
Lon E. Reed, 1315 Central, Hot Springs 1955
W. M. Eisele, Medical Arts Bldg., Hot Springs 1955

Transportation

Paul H. Woods, Medical Arts Bldg., Hot Springs, Chairman 1955
C. W. Parkerson, 1315 Central, Hot Springs 1955

Commercial Exhibits

Charles P. Harris, Medical Arts Bldg., Hot Springs, Chairman 1955
Vernon E. Sammons, Jr., Medical Arts Bldg., Hot Springs 1955
Richard F. Graham, Medical Arts Bldg., Hot Springs 1955

* Appointments made for more than one year to conform with new Constitution.

COUNTY MEDICAL SOCIETIES OF THE ARKANSAS MEDICAL SOCIETY OFFICERS FOR 1954

ARKANSAS COUNTY
President, R. H. Whitehead, Sr., DeWitt
Secretary, R. H. Whitehead, Jr., DeWitt

ASHLEY COUNTY
President, W. A. Regnier, Hamburg
Secretary, L. C. Barnes, Hamburg

BAXTER COUNTY
President, J. A. Van Beber, Gassville
Secretary, E. W. Bentzien, Mountain Home

BENTON COUNTY
President, Lee Dean, Rogers
Secretary, Stewart M. Wilson, Rogers

BOONE COUNTY
President, O. B. McCoy, Harrison
Secretary, Hugh M. Fogo, Harrison

BRADLEY COUNTY
President, Merl Crow, Warren
Secretary, Hogan A. Dew, Warren

CARROLL COUNTY
President, Ross Van Pelt, Eureka Springs
Secretary, James S. Priddy, Green Forest

CHICOT COUNTY
President, Gaither C. Johnston, Lake Village
Secretary, Pelham McGehee, Lake Village

CLARK COUNTY
President, P. R. Anderson, Arkadelphia
Secretary, H. D. Luck, Arkadelphia

CLEVELAND COUNTY
President, J. H. Scroggins, Fordyce
Secretary, W. G. Hancock, Rison

COLUMBIA COUNTY
President, J. H. Wilson, Magnolia
Secretary, Charles L. Weber, Magnolia

CONWAY COUNTY
President, Gastor B. Owens, Morrilton
Secretary, Thomas H. Hickey, Morrilton

CRAIGHEAD-POINSETT COUNTY
President, Rector C. Hooper, Jonesboro
Secretary, J. H. McCurry, Cash

CRAWFORD COUNTY
President, M. C. Edds, Mulberry
Secretary, G. K. Patton, 1309 E. Main, Van Buren

CRITTENDEN COUNTY
President, A. C. Parker, Clarkedale
Secretary, Robert H. Ray, Earle

CROSS COUNTY
President K. E. Beaton, Wynne
Secretary, Robert A. Hayes, Wynne

DALLAS COUNTY
President, H. H. Atkinson, Fordyce
Secretary, E. E. Estes, Fordyce

DESHA COUNTY
President, Charles Leverett
Secretary, Guy U. Robinson, Dumas

DREW COUNTY
President, J. B. Holder, Jr., Monticello
Secretary, J. P. Price, Monticello

FAULKNER COUNTY
President, N. E. Fraser, Conway
Secretary, B. F. Banister, Jr., Conway

FRANKLIN COUNTY
President, C. C. Long, Ozark
Secretary, David L. Gibbons, Ozark

GARLAND COUNTY
President, Leeman H. King, Med. Arts Bldg., Hot Springs
Secretary, R. H. Atkinson, Med. Arts Bldg., Hot Springs

GRANT COUNTY
President, Faber H. Carter, Sheridan
Secretary, Miles F. Kelly, Sheridan

GREENE-CLAY COUNTY
President, Byron Futrell, Rector
Secretary, Donald I. Purcell, Paragould

HEMPSTEAD COUNTY
President, Jud Martindale, Hope
Secretary, Wayne Lafferty, Hope

HOT SPRING COUNTY
President, Morgan C. Berry, Malvern
Secretary, Raymond C. Peeples, Malvern

HOWARD-PIKE COUNTY
President, Hiram Ward, Murfreesboro
Secretary, Don W. Chamblin, Nashville

INDEPENDENCE COUNTY
President, A. Meryl Grasse, Calico Rock
Secretary, Paul Gray, Batesville

Amebiasis[1] a "Poorly Reported" Disease

Until serious complications arise, amebiasis may pass unrecognized and patients receive only symptomatic treatment.

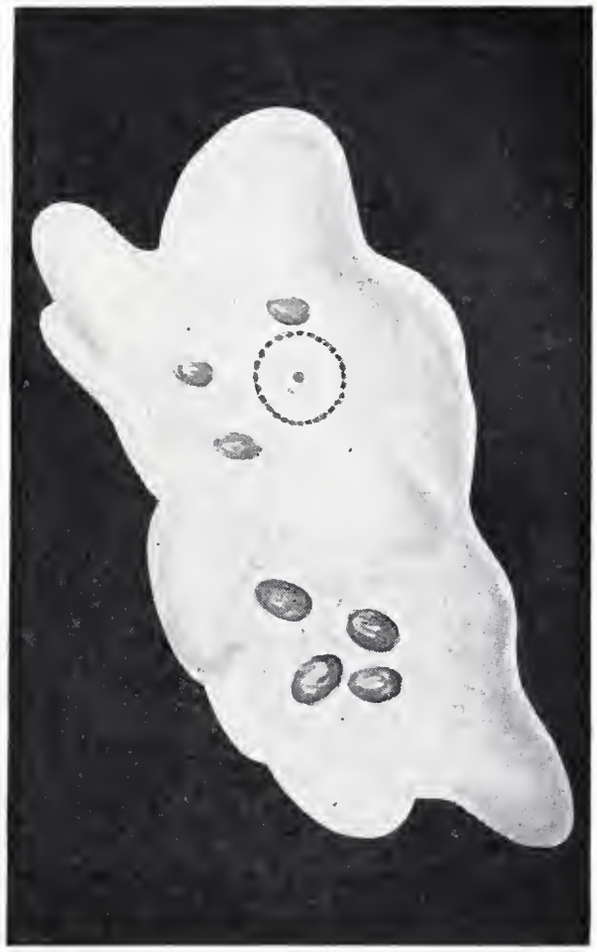
Although amebiasis is a disease with serious morbidity and mortality, statistics on its incidence[1] are incomplete because its manifestations are not commonly recognized and consequently not reported.

"*Vague symptoms[2] referable to the gastrointestinal tract, such as indigestion or indefinite abdominal pains, with or without abnormally formed stools, may result from intestinal amebiasis. Not infrequently in cases in which such symptoms are ascribed to psychoneurosis after extensive x-ray studies have been carried out, complete relief is obtained with antiamebic therapy.*"

To prevent possible development of an incapacitating or even fatal illness and to eliminate a reservoir of infection in the community, diagnosing and treating[3] even seemingly healthy "carriers" and those having mild symptoms of amebiasis is advised.

Early diagnosis[1] is important because infection can be rapidly and completely cleared, with the proper choice of drugs and due consideration for the principles of therapy. For treatment of the bowel phase these authors find Diodoquin "most satisfactory."

For chronic amebic infections, Goodwin[4] finds Diodoquin to be one of the best drugs at present available.



Endamoeba histolytica (trophozoite).

Diodoquin, which does not inconvenience the patient or interfere with his normal activities, may be used in the treatment of acute or latent forms of amebiasis. If extraintestinal lesions require the use of emetine, Diodoquin may be administered concurrently. It is a well tolerated and relatively nontoxic orally administered amebacide, containing 63.9 per cent of iodine.

Diodoquin (diiodohydroxyquinoline), available in 10-grain (650 mg.) tablets, reduces the course of treatment to twenty days (three tablets daily). Treatment may be repeated or prolonged without serious toxic effect. It is accepted by the Council on Pharmacy and Chemistry of the American Medical Association. G. D. Searle & Co., Research in the Service of Medicine.

---

1. Hamilton, H. E., and Zavala, D. C.: Amebiasis in Iowa: Diagnosis and Treatment, J. Iowa M. Soc. *42*:1 (Jan.) 1952.

2. Goldman, M. J.: Less Commonly Recognized Clinical Features of Amebiasis, California Med. *76*:266 (April) 1952.

3. Weingarten, M., and Herzig, W. F.: The Clinical Manifestations of Chronic Amebiasis, Rev. Gastroenterol. *20*:667 (Sept.) 1953.

4. Goodwin, L. G.: Review Article: The Chemotherapy of Tropical Disease: Part I. Protozoal Infections, J. Pharm. & Pharmacol. *4*:153 (March) 1952.

JACKSON COUNTY
Secretary, John D. Ashley, Jr., Newport

JEFFERSON COUNTY
President, Howard S. Stern, 1315 Linden, Pine Bluff
Secretary, Thomas Townsend, 1310 Cherry, Pine Bluff

JOHNSON COUNTY
President, Earle H. Hunt, Clarksville
Secretary, James M. Kolb, Clarksville

LAFAYETTE COUNTY
Secretary, R. H. Harrison, Lewisville

LAWRENCE COUNTY
President, Ralph Joseph, Walnut Ridge
Secretary, Chas. D. Tibbels, Black Rock

LEE COUNTY
President, W. C. Hayes, Marianna
Secretary, Floyd Dozier, Marianna

LINCOLN COUNTY
President, C. W. Dixon, Gould
Secretary,

LITTLE RIVER COUNTY
President, N. W. Peacock, Jr., Ashdown
Secretary, Joe G. Shelton, Jr., Ashdown

LOGAN COUNTY
President, A. B. Dickey, State Sanatorium
Secretary, Chas. McD. Smith, Paris

LONOKE COUNTY
President, H. E. McEntire, England
Secretary, Robert M. Kelley, Lonoke

MADISON COUNTY
President, L. E. Henderson, Marble
Secretary, Charles B. Beeby, Huntsville

MILLER COUNTY
President, A. A. Little, 6th and Walnut, Texarkana
Secretary, James B. Kittrell, 610 Walnut, Texarkana

MISSISSIPPI COUNTY
President, Charles W. Silverblatt, Osceola
Secretary, Jerome Gordon, Luxora

MONROE COUNTY
President, Ben F. Pupsta, Clarendon
Secretary, Jere Long, Brinkley

NEVADA COUNTY
President, C. P. Arnold, Prescott
Secretary, C. A. Hesterly, Prescott

OUACHITA COUNTY
President, J. L. Dedman, Jr., Camden
Secretary, R. B. Robins, Camden

PHILLIPS COUNTY
President, George Gibbons, Marvell
Secretary, Alfred A. Berger, Helena

POLK COUNTY
President, Frank A. Lee, Vandervoort
Secretary, John P. Wood, Mena

POPE-YELL COUNTY
President, Max Mobley, Russellville
Secretary, Wm. Ernest King, Russellville

PULASKI COUNTY
President, Clyde Rodgers, 1415 W. 7th Little Rock
Recording Secretary, Alfred Kahn, Jr., Donaghey Bldg., Little Rock
Executive Secretary, G. G. Fulmer, Donaghey Bldg., Little Rock

RANDOLPH COUNTY
President, N. K. Smith, Pocahontas
Secretary, M. A. Baltz, Pocahontas

ST. FRANCIS COUNTY
Secretary, J. O. Rush, Forrest City

SALINE COUNTY
President, John Ashby, Benton
Secretary, Theordore C. Swinyar, Benton

SEARCY COUNTY
President, J. O. Cotton, Leslie
Secretary, P. L. Evans, Marshall

SEBASTIAN COUNTY
President, Wright Hawkins, 100 S. 14th, Fort Smith
Secretary, James Thompson, 1610 S. "B," Fort Smith
Treasurer, Ben H. Pride, 323 North 13th, Fort Smith

SEVIER COUNTY
Secretary, Rodger Dickinson, DeQueen

SCOTT COUNTY
President, E. J. Brown, Mansfield
Secretary, Harold B. Wright, Waldron

UNION COUNTY
President, G. H. Landers, El Dorado
Secretary, C. D. Cyphers, 506 West Faulkner, El Dorado

WASHINGTON COUNTY
President, Wm. J. Stocker, Fayetteville
Secretary, Stanley Applegate, Springdale

WHITE COUNTY
President, Claude Barnett, Heber Springs
Secretary, Hugh R. Edwards, Searcy

WOODRUFF COUNTY
President, F. C. Maguire, Jr., Augusta
Secretary, C. E. Dungan, Augusta

U. C. MEDICAL CENTER LIBRARY
SEP 21 1954
San Francisco, 22

SEPTEMBER 1954

THE JOURNAL OF THE ARKANSAS MEDICAL SOCIETY

VOL. LI No. 4

FORT SMITH, ARKANSAS

FOR COMMON BACTERIAL INFECTIONS IN CHILDREN
ILOTYCIN
(ERYTHROMYCIN, LILLY), ETHYL CARBONATE
PEDIATRIC
PALATE-PLEASING • EFFECTIVE
ILOTYCIN • THE ORIGINAL ERYTHROMYCIN
Lilly

when resistance to other antibiotics develops...

PARKE, DAVIS & COMPANY • DETROIT 32, MICHIGAN

Current reports[1,2] describe the increasing incidence of resistance among many pathogenic strains of microorganisms to some of the antibiotics commonly in use. Because this phenomenon is often less marked following administration of CHLOROMYCETIN (chloramphenicol, Parke-Davis), this notably effective, broad spectrum antibiotic is frequently effective where other antibiotics fail.

Chloromycetin®

Coliform bacilli—100 strains

up to 43% resistant to other antibiotics;
2% resistant to CHLOROMYCETIN.[1]

Staphylococcus aureus—500 strains

up to 73% resistant to other antibiotics;
2.4% resistant to CHLOROMYCETIN.[2]

CHLOROMYCETIN is a potent therapeutic agent and, because certain blood dyscrasias have been associated with its administration, it should not be used indiscriminately or for minor infections. Furthermore, as with certain other drugs, adequate blood studies should be made when the patient requires prolonged or intermittent therapy.

References

(1) Kirby, W. M. M.; Waddington, W. S., & Doornink, G. M.: Antibiotics Annual, 1953-1954, New York, Medical Encyclopedia, Inc., 1953, p. 285.
(2) Finland, M., & Haight, T. H.: *Arch. Int. Med.* **91**:143, 1953.

THE

Journal

OF THE

Arkansas Medical Society

Owned by

THE ARKANSAS MEDICAL SOCIETY

And Published Under Direction of the Council

FOUNT RICHARDSON, M.D., Editor

316 West Dickson Street — Fayetteville, Arkansas

MR. PAUL C. SCHAEFER, Business Manager

215 Kelley Bldg. — Fort Smith, Arkansas

The Advertising policy of this JOURNAL *is governed by the rules of the Council on Pharmacy and Chemistry of the American Medical Association.*

EXCLUSIVE PUBLICATION—Articles are accepted for publication on the conditions that they are contributed solely to this JOURNAL.

COPYRIGHT, 1954—By The JOURNAL *of the Arkansas Medical Society.*

NEWS—Our readers are requested to send in items of news, also marked copies of newspapers containing matter of interest to the membership.

OFFICERS OF THE ARKANSAS MEDICAL SOCIETY

W. R. BROOKSHER, President....Fort Smith
L. H. McDANIEL, President-Elect....Tyronza
T. P. FOLTZ, First Vice-President....Fort Smith
ELDON FAIRLEY, Second Vice-President....Wilson
R. H. WHITEHEAD, SR., Third Vice-President....DeWitt
J. J. MONFORT, Secretary....Batesville
DANIEL H. AUTRY, Treasurer....Little Rock
T. DUEL BROWN, Speaker, House of Delegates....Little Rock
C. C. LONG, Vice-Speaker....Ozark
MR. PAUL C. SCHAEFER, Executive Secretary
215 Kelley Bldg., Fort Smith

COUNCILORS

First District—JOE VERSER....Harrisburg
Second District—HUGH R. EDWARDS....Searcy
Third District—J. MAX ROY....Forrest City
Fourth District—L. K. HUNDLEY, Chairman....Pine Bluff
Fifth District—D. E. WHITE....El Dorado
Sixth District—HARRY E. MURRY....Texarkana
Seventh District—H. KING WADE, JR....Hot Springs
Eighth District—H. ELVIN SHUFFIELD....Little Rock
Ninth District—FOUNT RICHARDSON....Fayetteville
Tenth District—J. M. KOLB....Clarksville

VICE-COUNCILORS

First District—WAYNE WORKMAN....Blytheville
Second District—JOHN SNEED....Conway
Third District—J. P. WILLIAMS, JR....Brinkley
Fourth District—H. W. THOMAS....Dermott
Fifth District—GEORGE BURTON....El Dorado
Sixth District—CHARLES YARBOROUGH....Texarkana
Seventh District—RANDOLPH ELLIS....Malvern
Eighth District—ROBERT D. JONES....Little Rock
Ninth District—LEE A. DEAN....Rogers
Tenth District—LOUIE A. WHITTAKER....Fort Smith

Notice on Form 3578-P to be sent to the Arkansas Medical Society, 215 Kelley Building, Fort Smith, Arkansas. Published monthly under direction of the Council, Arkansas Medical Society, at Fort Smith, Arkansas. Vol. LI. No. 4. Subscriptions $3.00 a year. Single copies, 50 cents. Entered as second-class matter, Sept. 23, 1947, at the post office at Fort Smith, Arkansas, under the Act of Congress of March, 1879. Acceptance for mailing at special rate of postage provided for in Section 1103, Act of October 3, 1917, authorized August 1, 1918.

• SPECIAL FEATURES

Committee on Cancer Control.... 85

Primary Gastric Resection in the Treatment of Perforated Gastroduodenal Ulcer.... 86

Intestinal Obstruction.... 90

Why I Entered Rural Practice.... 92

Medical Assistants Association.... 95

• FEATURES

Editorial.... 96

British Labor Fed Up With National Health Service.... 97

Academy Announces Noted Professor for 6th Annual Post-Graduate Assembly.... 97

Coming Meetings.... 97

Arkansas Traveling.... 98

Resolutions.... 98

Obituary.... 98

Tuberculosis Abstracts.... 99

Personals and News Items.... 101

Proceedings of Societies.... 102

The JOURNAL
OF THE ARKANSAS MEDICAL SOCIETY
PUBLISHED MONTHLY UNDER DIRECTION OF THE COUNCIL

Vol. LI September, 1954 No. 4

Committee on Cancer Control

C. A. ARCHER, M.D., Chairman

ROENTGEN THERAPY AS A PALLIATIVE MEASURE IN MALIGNANCY

The incurable cancer patient is offered his best chance for relief of pain and prolongation of life by roentgen therapy. Unfortunately, too many terminal or incurable cases are denied the relief which this procedure may bring and are too early condemned to a life with narcotic drugs. It is somewhat unusual to realize that other incurable diseases, such as heart and kidney diseases, benefit from aggressive steps toward relief of symptoms. The hopeless cancer patient is entitled to a similar considerate attitude from the profession. Obviously, palliative roentgen therapy will not prove beneficial to all such cancer patients but the radiologist should have the opportunity of decision in the individual case.

Favorable effects which may ensue from adequate irradiation will be healing of ulcerated lesions, freedom of pain, decrease in tumor size, relief of inflammation, control of hemorrhage, prevention of pathological fractures, improved outlook on life and a prolongation of a tolerable and useful life.

Contradictions to the employment of irradiation are moribund patients, those with cachexia, certain patients previously failing to realize benefits from palliative therapy and those malignancies of special types and those occurring in special locations.

It is the joint responsibility of the attending physician and the radiologist to offer this sometimes dramatic relief to many patients.

PRIMARY GASTRIC RESECTION IN THE TREATMENT OF PERFORATED GASTRODUODENAL ULCER

MARLIN B. HOGE, M.D., F.A.C.S. and ARTHUR F. HOGE, M.D., F.A.C.S.

It has long been accepted in this country, that simple closure of a perforated ulcer is the treatment of choice, as it most expeditiously corrects the defect causing the acute illness. Since a large percentage of these patients are not cured by simple closure and since there has been a marked improvement in the outlook of patients with acute gastroduodenal perforation in recent years, we believe that it is time for us to review our thinking concerning this matter. This marked improvement is attributed to the antibiotics and to improvement in surgical technique and anesthesia and more physiologic replacement of fluids and electrolytes. European surgeons were recommending primary gastric resection as the treatment of choice in perforated ulcers even prior to the advent of antibiotics because simple closure cured only a small percentage of these patients and their mortality and morbidity statistics were better with resection than with simple closure. The purpose of this study is to present criteria for the selection of cases of acute gastroduodenal ulcer perforation to be treated by primary gastric resection, and to present a case report.

There are four methods being used in the treatment of perforated ulcer today, namely: Medical management; simple closure, plus gastroenterostomy; simple closure; and gastric resection.

Medical Management

Medical management of perforated ulcers is mentioned, only to be condemned for routine use for the following reasons: First, it is difficult to be sure that continuous suction is being maintained in every case. Second, it is conceivable that suction may be adequate in perforated gastric ulcer but in perforated duodenal ulcer it is inevitable that the duodenum will be filled with fluids from an associated ileus before this fluid can be siphoned from the stomach. Third, there is a high rate of diagnostic error and it is frequently difficult to be certain that one is dealing with a perforated ulcer. Fourth, one assumes a terrific responsibility in treating a perforated ulcer medically, when he cannot be sure that the perforation is small enough and the tissues sufficiently healthy to permit its closure.

Medical management of perforated ulcers should be reserved for those patients who are suspicioned of having an acute coronary thrombosis or acute pancreatitis; those in whom the abdominal pain might be caused by pneumonia; those patients who are poor surgical risks for various reasons; and the occasional case seen after twenty-four hours that shows definite signs of localization.

Simple Closure, Plus Gastroenterostomy

Simple closure, plus gastroenterostomy has been advocated by some in an attempt to short circuit the area of ulceration, and thus to relieve pressure on the area of closure, or to obviate a possible obstruction. DeBakey and many others have shown that this procedure is not superior to simple closure alone, and that the high incidence of ulceration in the anastamotic loop of jejunum, make it undesirable. We believe that it is still a valuable procedure to keep in mind in rare cases with obstruction, who, for other reasons, are not in sufficiently good general condition to permit a more extensive surgical procedure.

Simple Closure

Since 1946, the results of treatment by simple closure have been uniformly good, when one considers the immediate mortality alone. Reynolds, et al., reported forty-three simple closures with no deaths. Jones and Doll reported three hundred and one cases with a 3.3% mortality. Gilmour reported two hundred and six patients, treated by simple closure, with a mortality of 6.3%. Mortality rates of other authors in the years 1941 to 1951 are shown in TABLE II. Practically all of the deaths were attributable to other factors, such as age over sixty, treated after twenty-four hours, or had other intercurrent disease. Gilmour reports an 18% mortality in patients over sixty years of age, Burbank and Roe report a 26% mortality, and Mage and Payson report a 36.7% mortality in the same age group. These authors all report a 4% mortality in patients under sixty. In patients operated under twelve hours, Gilmour reports 3% mortality, Burbank, Roe, and Benson 3.8%, and Mage and Payson 3.5% mortality. In Gilmour's series of cases the mortality rate rose to 18% in those operated between twelve and twenty-four hours and to 40% in those operated after twenty-four hours. Burbank reports an 18.5% mortality rate in patients operated after twelve hours. Mage and Payson report a 30% mortality in those operated between twelve and twenty-four hours.

Gilmour classified his cases of perforated ulcer as acute or chronic by correlating the pre-operative clinical history with the pathologic changes found at operation. In his series, one hundred and nineteen cases were classified as acute, with no mortality, and eighty-seven were classified as chronic, with a 15% mortality. In a three to seven-year follow-up on one hundred and eighty-nine patients, he found that five died of intercurrent disease and three from conditions directly associated with the original ulcer. He classified his results as satisfactory in 35%, moderate in 16%, and poor in 50% of cases. The ultimate prognosis was classified as good in more than 75% of the acute ulcer cases and only 10% required further surgery. In sixty-five chronic ulcer cases, all relapsed, 63% required further surgery in three to seven years, and the remainder were still under medical treatment.

Jones and Doll classified their cases as chronic if the patient gave a history of dyspepsia over one year's duration prior to perforation, or had a confirmed history of ulcer. Forty-one per cent of the patients who survived and who gave a history of dyspepsia of more than one year, and 50% of the patients in whom the presence of an ulcer had been proved before perforation occurred were operated on again during a follow-up of two to twelve years. On the other hand, only 18% of the patients who gave a history of dyspepsia of less than one year, and 22% of those in whom the presence of an ulcer had not been proved, required further surgery. Glenn and Harrison reported that 47.8% of their series of one hundred and fifteen patients required further surgery in a one to nineteen-year follow-up. Illingworth, et al., in a follow-up of seven hundred and thirty-three cases, reported 10% good results, 70% moderate to poor results, and 20% required further surgery.

Gastric Resection

In 1902, Keetley performed a gastrectomy for perforated ulcer, as also did von Haberer in 1919. Since then, this has been the popular method of treatment on the Continent of Europe. In 1939, Yudine (Russia) reported nine hundred and thirty-seven partial gastrectomies for perforated ulcer, with a mortality rate of 8.9%. This was compared with four hundred and thirty-five palliative operations, with a mortality rate of 31.7%. Haberlin reported two hundred and fifteen gastric resections with a mortality rate of 4.6% in the years 1941-1952. This was compared with ninety-two simple closures, with a mortality rate of 32.6%, and eleven cases treated medically, with a 63% mortality rate. In 1952 Carayannopoulos reported sixty-nine partial gastrectomies, with a mortality rate of 2.9%. This was compared with thirty-nine cases treated by simple closure, with a 28.2% mortality rate, and three cases treated medically, with no mortalities. Lowden reported fifty-one partial gastrectomies in 1952, with no deaths, compared with fourteen patients treated by other measures, with four deaths. Emmett and Owen reported forty-six cases treated by partial gastrectomy in the years 1947-53, with no deaths. Brockman, Cooley, and DeBakey reported a series of forty-seven gastric resections in 1953, with one death. Jones and Doll reported thirty partial gastrectomies, with no mortalities, in the years 1947-51. This was compared with three hundred and one simple closures, with a mortality rate of 3.3% and twenty patients treated medically, with an 85% mortality. All of these authors limited their cases of gastric resection to those patients thought to be a good surgical risk. In addition to this, Jones and Doll limited their cases of gastrectomy to those patients under sixty-five years of age; Carayannopoulos to those under fifty-five years of age and operated under eight hours. The total consists of four hundred and fifty-five patients on whom primary partial gastrectomy was performed, with thirteen deaths, or a mortality rate of 2.8%. This compares favorably with elective partial gastrectomy for benign ulcer.

Jones and Doll reported that 5% of their patients surviving simple closure died as the result of their ulcers within an average of six years. This is a serious increment to the immediate mortality and indicates the need for more radical surgery in selected cases.

As it has been previously shown, 20 to 50% of unselected perforated ulcers treated by simple closure or medical management require further surgery, and 50 to 63% of ulcers classified as chronic require further surgery. Rauch reports 90% good results in a long term follow-up of perforated ulcers treated by primary partial gastrectomy, and Emmett and Owen report 80% good results.

Discussion

It has been shown that immediate partial gastrectomy in perforated ulcers is a practical method of treatment, with an excellent immediate prognosis and an improved remote prognosis in selected cases. Since acute perforated ulcers have an excellent immediate and remote prognosis by simple closure alone, and only 10% require further surgery, it is believed that these patients should not be treated by partial gastrectomy. If subjected to partial gastrectomy, a few

would obtain a poor result that might have obtained a good result by simple closure. On the other hand, 50 to 63% of those patients with a long standing history of ulcer, X-ray evidence of ulcer, or operative findings of previous ulcer activity will require further surgery. As was shown by Gilmour, all of these patients with chronic ulcers will relapse and be classified as a poor result when treated by simple closure alone.

For these reasons, we believe that all chronic ulcers with perforation should be subjected to immediate partial gastrectomy if the patient has no cardiac, pulmonary, renal, or other pathology that would contraindicate an extensive surgical procedure, and if the patient can be operated before there is peritonitis of a serious degree.

Case Report

Mr. J. E., a thirty-two-year-old white male, had a sudden onset of severe pain in the epigastrium two hours before admission. He had had a perforated ulcer two years earlier that was treated by simple closure. He stated that he had not had a minute free of pain during the past year and that he had been unable to eat anything but milk and raw eggs during the past few months. His symptoms and the physical findings were typical of acute perforated ulcer, and he was subjected to laparotomy two hours and forty-five minutes after the onset of his illness. On opening the abdomen, a perforation was found at the pylorus. There was very little fluid in the peritoneal cavity and only slight local inflammatory reaction. There were many organized adhesions between the duodenum, stomach, and liver. The question arose whether to treat this individual by simple closure of his ulcer or by gastric resection. Simple closure would have been difficult because of the size of the opening and the marked cicatrization, and a subsequent gastric resection would have been necessary to cure him. It was decided that this patient was as good a candidate for partial gastrectomy at this time as he would be at a later date, and that by performing it at this time, a second operative procedure, with its attendant mortality and morbidity, could be avoided. A gastric resection was performed, removing the distal two-thirds of the stomach, together with the ulcer at the pylorus. An anticolic Polya gastrojejunostomy was performed. One month later he stated that he was symptom free, could eat any food without difficulty and as large a quantity as he desired.

Conclusion

In conclusion, we have adopted the following criteria for primary gastric resection in perforated ulcers.

The first criteria is that the patient should be in good general condition and should not have any cardiac, pulmonary, renal, or other pathology that would contraindicate an extensive surgical procedure. If the patient fulfills these requirements and presents any of the following conditions, then we consider him a candidate for primary gastric resection.

(1) Perforated gastric ulcers. Perforated gastric ulcers should be resected as there is always some question as to whether there is a hidden carcinoma, and Gilmour has shown that the results are poor in 50% of these patients treated by simple closure. In addition to this, Jones and Doll have stated that 11% of these patients can be expected to develop carcinoma at a later date.

(2) Hemorrhage at the time of perforation or previous history of hemorrhage. Hemorrhage from a perforated ulcer is frequently not arrested by simple closure, and further hemorrhage or perforation is to be expected in those with a previous history of hemorrhage.

(3) Chronic ulcers. Patients with a long history of ulcer or previous X-ray evidence of ulcer and pathologic findings of a chronic ulcer cannot be expected to obtain a good result by simple closure, and primary gastric resection is considered by us to be the treatment of choice. Gastric resection is even more imperative in these patients if there is a previous history of perforation, as 50% of them can be expected to perforate again when treated by simple closure. The remaining 50% will have a recurrence of their ulcer, and most of them will require further surgery.

Simple closure is still the treatment of choice in acute perforated duodenal ulcer.

I. SIMPLE CLOSURE—MORTALITY RATE
1947-1953

Authors	No. of Cases	No. of Deaths	Mortality Rate
Reynolds, et al.	43	0	0
Jones and Doll	301	10	3.3%
Gilmour	206	13	6.3%
TOTAL	550	23	4%

II. SIMPLE CLOSURE—MORTALITY RATE
1941-1951

Authors	No. of Cases	No. of Deaths	Mortality Rate
Mage and Payson	187	12	7.2%
Beahrs, et al.	102	3	2.9%
Reynolds, et al.	125	12	9.5%
Craighead	59	6	10%
Glenn & Harrison	59	6	10.2%
Kingsbury and Peacock	169	16	
TOTAL	701	55	7.8%

III. PER CENT REQUIRING FURTHER SURGERY AFTER SIMPLE CLOSURE

Authors	No. of Cases	Follow-Up in Years	Per Cent
Glenn	115	1-19	47.8%
Illingworth	733		20%
Jones and Doll	109	2-12	33%
Gilmour	116 (Acute)	3-7	10%
	65 (Chronic)		63%

IV. GASTRIC RESECTION—MORTALITY RATE

Authors	Years	No. of Cases	No. of Deaths	Mortality Rate
Haberlin	1941-51	215	10	4.6%
Carayannopoulos	——-1952	69	2	2.9%
Lowdon	——-1952	51	0	0
Emmett	1947-53	46	0	0
Brockman	1951-53	44	1	2.2%
Jones and Doll	1947-53	30	0	0
TOTAL		455	13	2.8%

REFERENCES

Beahrs, Oliver H., Duncan Douglas K., and Vadheim, Lewis A. Emergency Surgical Treatment of Perforated Gastric and Duodenal Ulcers. Surg., Gynec. and Obst., 1953, 96: 637-640, June.

Brockman, H. Leroy, Cooley, Denton A., and DeBakey, Michael E. Acute Gastroduodenal Perforation; an Analysis of Forty-four Cases Treated by Immediate Gastrectomy. Am. Surgeon, 1953, 19: 182-190, Feb.

Burbank, Charles B., and Roe, Benson B. Recent Experiences with Acute Perforation of Peptic Ulcers at the Massachusetts General Hospital. New England J. Med., 1952, 247: 424, September.

Carayannopoulos, George, and Christopoulos, Christos. Gastric Resection as the Treatment of Perforated Gastroduodenal Ulcer. Surgery, 1952, 32: 784, November.

Craighead, Claude C. Surgical Management of Peptic Ulcer. New Orleans M. and S. J., 1952, 104: 525-530, July.

DeBakey, Michael E. Acute Perforated Gastroduodenal Ulceration. Surgery, 1940, 8: 852-884, Nov.; 1028-1076, Dec.

Emmett, J. M., and Owen, E. T. Gastrectomy As a Treatment for Perforated Peptic Ulcers. Ann. Surg., 1953, 138: 320, September.

Gilmour, John. Prognosis and Treatment in Acute Perforated Peptic Ulcer. A Review of 206 Cases. Lancet, 1953, 1: 870, May.

Glenn, Frank, and Harrison, Charles S. Acute Free Perforation of Peptic Ulcer: complication of Ulcer Diathesis. Am. M. A. Arch. Surg., 1952, 65: 795-804, Nov.

Haberlin, P. Therapy of Perforated Ulcers of Duodenum and Stomach. Experiences of the Zurich Clinic on the Basis of 318 Cases Between 1941 and 1952. Schweizerische medizinische Wochenschrift, 1953, 83: 571, June.

Illingworth, C., Scott, L., and Jamieson, R. Progress After Perforated Peptic Ulcer. Brit. M. J., 1946, 1: 787.

Jones, F. Avery, and Doll, R. with the assistance of Keena Jones and Barbara White. Treatment and Prognosis of Acute Perforated Peptic Ulcer. Brit. M. J., 1953, 1: 122, January.

Keetley, C. B. Surgery of Non-Malignant Gastric Ulcer and Perforation. Lancet, 1902, 1: 885 and 955.

Kingsbury, Henry A., and Peacock, Erle E., Jr. Acute Perforation of Peptic Ulcer. Surg., Gynec. & Obst., 1951, 92: 717-720, June.

Lowdon, A. G. R. The Treatment of Acute Perforated Peptic Ulcer by Primary Partial Gastrectomy. Lancet, 1952, 1: 1270, June.

Mage, Sigmund, and Payson, Benjamin A. A Consideration of the Present Status of Simple Suture in the Treatment of Acute Perforated Gastroduodenal Ulceration: Surg., Gynec. & Obst., 1952, 94: 581-590, May.

Rauch, R. S. Evaluation of Gastric Resection; review of 893 cases. Surgery, 1952, 32: 638.

Reynolds, Roland P., Cantor, Meyer O., and Stebbins, Charles. Treatment of Perforated Peptic Ulcer in a General Hospital. J. Michigan St. M. Soc., 1950, 49: 807-808, July.

Rose, Thomas F. Perforated Peptic Ulcer; the Mortality and Morbidity of Treatment. M. J. Australia, 1950, 1: 421, April.

Von Haberer, H. Wiener klinische Wochenschrift, 1919, 32: 413; quoted by Rose, Thomas F., loco citato.

Yudine, Serge. Edute sur les ulceres gastriques et duodenaux, perfores. J. Internat. de Chir., 1939, 4: 219; quoted by DeBakey, Michael E., loco citato.

INTESTINAL OBSTRUCTION*

DANIEL J. MOOS, Minneapolis, Minnesota

Stoppage of the bowels has presented a grave problem to surgeons from the dawn of medical history to and including the present era of surgical achievement. If the plight of the unfortunate individual who was the subject of intestinal obstruction were not so grave the antics and remedies employed even in the near past of the 19th century would stimulate one's humorous emotions. The advice that when all else had failed to produce the desired evacuation ingestion of musket balls and quick silver was to be considered evokes the thought that in medical as well as surgical practice heroic measures were not unknown. Sadly enough even today the massive irritant clyster occasionally continues to be repeated in individuals who should hours or days before have been considered candidates for surgical relief of their obstructive symptoms.

External hernia and adhesive bands remain the common cause of intestinal obstruction. The latter may be congenital or postinflammatory but are usually the result of abdominal surgery. The role of talc has been pointed out by Antopol [1] in 1933 and its subsequent emphasis by many authors reminds us of its danger. When one considers Lee and Lehman's [2] experiment of injecting talc into the peritoneal cavity of dogs thereby producing death from adhesive intestinal obstruction regularly great respect for the irritative qualities of this substance is established. The replacement in most hospitals of talc glove powder with hydrolyzed starch is a marked improvement. However, the complete removal of even this substance from the external surface of the rubber glove before the hand enters the peritoneal cavity is of importance for there is evidence to suggest that its presence on peritoneal surfaces may not be entirely innocuous. Intussusception, gallstone obstruction, volvulus, internal hernias and primary neoplasms of the bowel in decreasing order of frequency are responsible for the great majority of the remaining instances of intestinal obstruction.

It is my wish at the outset to make clear that with the exception of complete obliteration of the peritoneal cavity by an adhesive process conservative treatment of intestinal obstruction is dangerous and irrational. Intestinal intubation, replacement of fluid, blood, and electrolyte loss along with administration of antibiotics are indeed important aids to therapy in this field. Persistence in their use with the hope of avoiding surgery is the path of folly which leads to the sad spectacle of an irretrievable patient. It has been my experience that the differentiation of the strangulating obstruction from the simple obstruction is brought with many difficulties and cannot be made with certainty. The hazards of long continued distention, electrolytic loss, toxic absorption and friable bowel are avoidable by early surgical treatment of the problem. Just as surely as one recognizes the logic of saving a man who is hanging by the neck from a rope by cutting him down, so must the scissors and scalpel of the surgeon sever the adhesion that threatens the life of the victim of intestinal obstruction. The well developed roentgenologic signs of distended bowel should ideally never be seen in full pattern for the obstruction should be recognized and released before it has progressed to that point. If this objective is sought and obtained, the grave problem becomes greatly simplified.

The symptom complex of intestinal obstruction when considered with the history relative to the problem offered by the patient at once serves to point out the patho-physiologic processes at play and confirm the clinical diagnosis. Laboratory and roentgenologic aids of course assist but considered alone are unreliable and may trap the unwary and lead him into errors of procedure and diagnosis. Pain of rhythmic nature due to distention of the gut as a peristaltic wave ineffectually attempts to force intestinal contents past the obstructed point is a constant and important finding. When such a pain defined by the patient as a cramp is associated at its height by high pitched tinkling intestinal noises often audible without stethoscope one must consider the diagnosis of acute intestinal obstruction unless definite evidence to the contrary is present. Reverse peristalsis makes itself prominent by the vomiting which in a high obstruction may be severe and in a low or large bowel obstruction late or absent. Bowel content during the course of three to four days in the obstructed gut decomposes by bacterial action to produce the so-called fecal type of vomit. Dependent on the amount of vomiting which is usually high in high small bowel obstructions and low in low obstructions, dehydration due to large volumes of water being lost and electrolyte disturbance consequent to loss of sodium and chloride develop. Usually chloride losses pre-

* Read before the Seventy-eighth Annual Session of the Arkansas State Medical Society, April 19, 1954.

dominate over loss of base and an alkalosis is the net result. It must be borne in mind that these latter changes diminish in intensity as one nears the ileo-cecal valve and colon. Shock may be a part of the clinical picture when strangulation of bowel favors loss of large amounts of blood into the damaged area. Obstructions low in the bowel allow for greater intestinal distention simply because more bowel above the lesion exists to be distended. When inflammatory peritoneal responses to dead or dying bowel begin, spasm of abdominal musculature and tenderness to palpation appear. Under these circumstances aspiration of the peritoneal cavity is of great aid for recovery of blood tinged fluid strongly indicates the presence of a strangulating obstruction. When failure to pass gas or feces is associated with the foregoing evidence, especially if one demonstrates the presence of an abdominal scar, preparation for surgical treatment of the individual should begin.

Rapid estimation of the state of hydration and electrolyte balance can best be made on the clinical evidence available. In marked dehydration we know that from 5 to 7 per cent of the body weight has been lost in the form of water. We also know that vomitus contains sodium and chloride in proportion of about one-half that of plasma. Therefore, dilute salt solution 0.45 per cent in $2^1/_2$ per cent glucose may be administered by vein. One-half of the total calculated deficit may be given in the first hour safely and the remainder during surgery and the immediate postoperative period. One's judgment should suffice to estimate the degree of dehydration to a degree which is accurate enough to begin therapy of dehydration and salt loss intelligently. In this regard it is to be remembered that even as loss of water and salt is a prominent cause of death in intestinal obstruction so too may be energetic overloading of the ill individual with fluid and electrolyte excesses. The laboratory aids of sodium, chloride, potassium bicarbonate, white blood count, hemoglobin and hematocrit determination are necessary and indeed invaluable as base line guides to eventual handling of complicated problems in fluid balance which these people may present. Initiation of therapy however must not await the completion of these calculations for valuable time may be lost. If shock is a presenting feature blood transfusion of course is necessary.

Intubation of the small intestine combats distention of the bowel with its concomitant absorption of toxic products of decomposed bowel content. Double lumen tubes rarely suffice for this purpose because their caliber is invariably too small. A single large lumen tube with a terminal mercury weighted bag has proved most satisfactory. This is passed through the nose to the pyloric ring under fluoroscopic control removing all kinks and loops from the tube. The patient is then placed on his right side and two swallows of water which is as hot as can be tolerated by the patient are given every twenty minutes. At the same time the tube is advanced one to two inches. In one hour X-ray study is made to determine where the tip of the tube lies. In the majority of instances using this technique the pylorus will be easily passed and the tube may be rapidly advanced while continuous suction is applied to empty the bowel. This simple method of intubation has in our hands proven highly satisfactory. In view of the fact that neomycin and related antibiotics rapidly sterilize the bowel it is our custom to inject such an agent through the tube as soon as the pylorus has been passed allowing thirty minutes before resuming suction. This is repeated at intervals for the purpose of rendering more innocuous the bowel content should it subsequently contact the peritoneal cavity. Streptomycin and penicillin are administered in appropriate dosage parenterally.

In such fashion the patient is rapidly prepared for operation. The length of time involved in preparation varies with the urgency of the symptoms and the answer to the question "What is to be gained by further preparation?" If one's answer to the latter is "Little or nothing" it is time to operate. If an obvious strangulating obstruction of massive and fulminating nature presents the shortest possible preparation is indicated. If, on the other hand, when obstruction of several days associated with marked distention, normal temperature and white count with no evidence of peritoneal irritation is seen, more leisurely preparation may be of value. In this case 24 hours of intestinal suction may markedly improve the patient and facilitate surgical manipulation. If one is guided by the principle that intestinal obstruction is a surgical problem and that preparation for operation is merely an adjunct not a definitive method, fewer lives will be lost from this catastrophe.

It is beyond the scope of this address to describe operative technique in detail. The principles which can offer much are as follows. Selection of anaesthesia is, of course, important. However, in the last analysis that method which the anaesthetist is most proficient with is likely the best. One cannot, in conjunction with this, reiterate too often the necessity for an empty stom-

ach even though it necessitates another nasal tube. More than one patient has literally drowned when a distended stomach has been manipulated during surgery. Make sure the stomach is empty. Incisions preferably of transverse type should be intelligently placed—not made where or of a type which the surgeon uses by habit. Aseptic decompression of the intestine as advocated and described by Wangensteen [3] is of inestimable value in dealing with distended bowel at operation which renders exposure of the pathological process difficult or impossible. Often times further manipulation of the inlying long intestinal tube may accomplish the same purpose. Strangulated or badly damaged bowel must be resected and intestinal continuity re-established by end to end anastomosis. It is here that a closed aseptic type of anastomosis is appealing because of the highly virulent nature of bowel content. Injection of neomycin into the bowel preoperatively through the nasal tube or at the time of surgery directly through the bowel wall partially mitigates this hazard. With the addition of parenteral antibiotic therapy open anastomoses with careful prevention of gross soilage are often successful. No brief is held for exteriorization of necrotic bowel save perhaps in the semi-moribund infant with intussusception. Gentle surgical manipulation with avoidance of strenuous gauze packing and introduction of foreign materials negate the production of new adhesions. This applies to surgical procedure for obstruction as well as any operative exercise. Short circuiting intestinal anastomoses in the main are condemned save for ileotransverse colostomy when obstructions in the right colon exist. Left colon obstructions yield occasionally to intubation of the obstructed area with a long rectal tube. This is especially true of volvulus of the sigmoid. In the main transverse colostomy is the procedure of choice in left colon obstructions with the exception of sigmoid volvulus. Careful preoperative barium enemata (never barium by mouth) with immediate removal are of inestimable value when one suspects a large bowel obstruction.

Conclusions

1. Early operation is the treatment of choice in acute intestinal obstructions.
2. Replacement of fluid and electrolyte loss, relief of distention, antibiotic therapy, and blood transfusion are important adjuncts to treatment.
3. Diagnosis on the basis of the history and physical findings is accurate. X-ray and laboratory determinations are of secondary importance.

BIBLIOGRAPHY

1. Antopol, W.: Lycopodium Granuloma, Its Clinical and Pathological Significance Together with Note on Granuloma Produced by Talc. Arch. of Pathology 16:326, Sept., 1933.
2. Lee, C. M. Jr., and Lehman, E. P.: Experiments with Non-Irritating Glove Powder; Surg., Gynec. & Obst. 84:689, 1947.
3. Wangensteen, Owen: Intestinal Obstruction, Ed. 2, Springfield, Illinois, Charles C. Thomas Co., 1942.

WHY I ENTERED RURAL PRACTICE

BEN H. SALTZMAN, Mountain Home, Arkansas
President-Elect Arkansas Academy of General Academy

I entered Rural Practice for one simple reason. I needed to earn a living.

The end of World War II found me in the Panama Canal Zone with sufficient points and dependents to get out of the Army.

I had several applications in the fire for a psychiatric residency, when I received a long distance phone call from my brother-in-law, also a physician located at Batesville, Arkansas. He informed me that the blossoming town of Mountain Home, Arkansas, was in need of another physician, and that it was an excellent opportunity to start making money almost at once.

Women are usually very impractical about these things, but I felt that I should discuss the situation with my wife. Our prolonged conversation went something like this: "This opportunity sounds fine," I said, "But I would like to specialize in psychiatry."

Betty asked, "When do you plan to start earning a living?" In two weeks I was investigating office space in Mountain Home.

But don't get me wrong. The economic factor and Betty's uncompromising attitude were not the only reasons for this decision.

Every man undertaking the study of medicine has behind him a dream. It may be based upon

acquaintance with a physician in childhood. It may be based upon an outstanding novel or motion picture. It may be based upon hearsay or parental suggestion. But the dream is there. It is a dream of service to mankind.

I don't care how hard-boiled you are. Each one of you sitting in front of me today, is here because at one time or other, you felt that you wanted to alleviate suffering.

Many of you have become disillusioned. In many cases you have felt that people weren't worth the effort. I had been exposed to the same doubts, and six years in the Canal Zone had me pretty well disillusioned as to both my capabilities and my prospects for the future.

So, the idea of rural practice intrigued me. It was certainly different from anything I had ever before experienced. I was a big city boy most of my life. The idea of a home in a small town became very appealing.

I had read about the lake development in Baxter County and about Arkansas being the land of opportunity. I could visualize myself fishing and hunting all year round and carrying on a nice, conservative country practice.

Too, four years in the Army does not leave one financially independent. In agreement with Betty, the idea of making a living was important. I wasn't getting any younger!

Many promises to influence my decision were made to my brother-in-law. These he related to me over long-distance phone. I was to have an office completely set up, a car and a home. These were important items in those days, and very tempting. This was not to be charity. I would pay for them out of my earnings.

And then, there was the dream. Somehow, somewhere, I wanted to be appreciated. I wanted my services to be recognized and I wanted this recognition to be based upon my ability to help others. There was the challenge.

What better way was there for me to find out if I was really a doctor, than to go to the people and let them tell me. And in rural practice, believe me, they tell you!

Against these incentives, I weighed the advantages of specialization. There weren't many. Four more years of institutional work toward a specialty board and then perhaps a lifetime of institutional work did not seem appealing after the restrictions of socialized medicine under the auspices of the Panama Canal and Army authorities. Perhaps the working hours would be better, but an office clerk has excellent working hours too. Financially speaking, a psychiatric specialty did not hold much promise.

Rural practice hit me with a bang. The promises that were made were made out of thin air. There was no office, no car, and no home. No one admitted making these promises.

I won't bore you with details. Dr. E. M. Gray, a retired physician, rented me his old office, I slept in a back room, and Betty's jalopy served as transportation.

The beginning was disillusioning except for one thing. That was the friendliness of the people. They made me feel that they wanted me, and gave me confidence in my ability.

I found that I had to be entirely self-reliant. Consultation was out of the question and most of the local inhabitants did not want to be sent off to distant cities.

I became the family doctor and was expected to know everything about everything. My idea of a leisurely country practice was soon abandoned. It is enough to say that in eight years, I have gone fishing four times.

The thing that always amazed and delighted me was the large variety of illnesses and accidents that came my way. I learned a lot of medicine in a short time. I had to.

Don't ever sell the country doctor short. He knows a great deal of practical medicine and usually has an up-to-date library.

The people wanted modern medicine. They too had been subjected to the influence of the Reader's Digest!

As my practice grew, so did my problems. I had to begin a process of education. The idea of chasing myself around rocky river bottoms on useless calls, helped neither my temper nor my car. My patients were told bluntly or subtly, depending upon how much sleep I had had, to bring their ailments to the office if they could move at all. The difference in cost was emphasized with telling effect.

Before I began rural practice I had promised myself that I would do as little obstetrical work as possible. I just didn't care for it. Yet, in three years, I had delivered almost 1,000 babies in the homes. It was explained to me by my friend, Dr. Gray, that "when you deliver a baby, you treat the entire family."

He taught me another thing for which I have always been grateful. He advised me to take the emphasis off money. "Treat your patient first, then ask for your pay, and don't charge too

much," I was told. It was good advice. I still have trouble paying my income taxes.

One argument against rural practice is usually the fact that there are no laboratory facilities. I answered that argument by installing my own. As my office grew, so did my diagnostic facilities. These have become quite adequate.

With an ever-increasing practice it became necessary that I get some help. An associate was the answer to that problem. Sharing the work made the practice of medicine really enjoyable. Now there was time for attendance at medical meetings, indulgence in civic and community affairs, and for some leisurely activity.

Another question that probably has come to your minds is "what about hospital facilities?" There were none. The community felt that it could not afford to build a hospital. So I built one myself. It consisted of 12 private rooms with modern equipment for medical, surgical and obstetrical treatment and was approved by the A.M.A. and American Hospital Association.

I had always heard that hospitals, privately owned are a headache and a financial drain. This may be true, but I get a great deal of satisfaction out of running the place to suit myself rather than by being run by a board of directors and by rules and regulations set up by the nursing staff. And as I said before, I still have trouble paying my income taxes.

Now to get back to life in the rural community. I was invited early to participate in civic and community affairs. In the small town, the physician's opinion is respected in many fields other than medicine. His advanced education in the liberal arts and sciences makes him a man who should be able to speak with authority.

Since coming to Mountain Home, I have been elected to the City Council, the board of directors of the Chamber of Commerce, the presidency of the Rotary Club, District Governor of Rotary International, Exalted Ruler of the Elks, and District Deputy of the Elks for Arkansas. I was just installed as Commander of the American Legion Post. I cite these activities, not in a spirit of braggadocia, although I am proud of the honors, but to illustrate the opportunities presented to the rural physician not only as a doctor, but also as a community leader.

The small town patient likes his physician to be well educated. He is pleased when his doctor attends medical meetings, although he is sometimes angry when he is not on tap in an emergency. Contrary to the medical economics authorities, the patient likes to see diplomas and certificates on the wall. My office wall looks like a section of Antoine's restaurant.

I am the last person to speak against competition, but in the small communities, the cut-throat factor is minimized both from the medical and from the civic points of view. The friendly attitude extends into all aspects of rural behavior.

From all this you may expect me to break into a chorus of "Dear Hearts and Gentle People," but I do not intend to neglect some of the unpleasant aspects of rural practice. They should be examined out in the light, although most of them occur in the dark!

I have delivered many a baby by oil lamp in a well ventilated shack in the middle of winter. This has been corrected to a large extent with the new available hospital facilities. I have been called out of bed many times to treat conditions that have existed for months, the excuse being that transportation was not available until that late hour.

Small town gossip is a major item to be reckoned with. There isn't a doctor anywhere within or near Mountain Home who has not been accused of taking dope. The physician's moral character is always being questioned.

I recall my early days of practice in Mountain Home. I was trying to establish some sort of professional manner and was making an attempt at being the fatherly type of physician, the "good old family doctor." A patient came to me soon after I opened my office. Her ailments were not serious. In my most dignified manner, I reassured her that she did not need the long list of expensive procedures that she had outlined.

Oh, I was very much the fatherly physician. As she was about to leave the office, I reached over and patted her hand, even got up and walked to the door with her. The next day it was all over town that "the new doctor had made a 'pass' at one of his patients."

Believe me, she wasn't even my type! Perhaps I wasn't the type to be a "good old family doctor."

The physician is very much in the public eye in a small town and he does have to use good sense. He should not drive too many Cadillacs or hold himself aloof from the general public.

Here, his wife is important. I had some trouble becoming accustomed to the quaint expressions of the country people at first. Imagine my surprise when I heard one lady telling another that the doctor's wife is all right, "She is common, like us."

It is also surprising how many so-called indiscretions will be forgiven if the physician is fair to his patients. He'll be talked about, but he will be patronized!

Rural practice has changed in many ways. When I began my work in Mountain Home, there was only one partially paved state road leading into the town. Today, there isn't a state highway leading into or leaving the community that is not completely paved. A set of tires lasted about 300 miles at first. I can now get 3,000 miles per set. The county roads still leave a great deal to be desired.

Rural electrification has also helped considerably. A few years ago, I treated many seriously ill patients and delivered many babies by oil lamp or pocket flashlight. Today, 95% of the rural homes have electricity.

Social aspects have also changed. Mountain Home with a population of 2,300, has 53 different clubs and organizations. There are not enough days in the week to attend all the meetings of groups to which one belongs. Motion picture theaters, drive-in theaters, radio and television have made rural life just as interesting as life in a big city. There is no longer the sense of isolation once felt in rural existence.

As family men, we also must think of educational facilities for our children. These have improved remarkably in the past few years. The consolidation of rural schools has raised educational standards and facilities almost on a par with metropolitan schools. Children grow up in a healthy, moral environment, that contrasts favorably with the urban setting. Delinquency rates are much lower.

This has been a rather rambling discussion of rural practice but it may serve to crystallize some of its advantages in your minds. Those of you who have spent some time with me in the preceptorship program have heard me outline the advantages of rural practice from time to time.

For the others, let me enumerate the things I believe are important:

1. The friendship and respect of patients.
2. A pleasant environment.
3. Unlimited opportunities for varied practice and self-improvement.
4. Economic security.
5. Participation in civic and community affairs.
6. Less "cut-throat" competition.
7. The opportunity for recognized service to humanity.

I have no desire now to go into a specialty. My eight years in Mountain Home have been very rewarding in every sense.

I wish all of you could come up to see the little town of which I am very proud. I feel that I have helped make it that kind of town.

When the time comes and you are faced with indecision, give rural practice a whirl.

You may find a town of your own.

MEDICAL ASSISTANTS ASSOCIATION

In an earlier P. R. Column it was suggested that it would be a fine thing if an organization of doctors assistants could be formed in Arkansas. Shortly afterward this writer was given the welcome information that just such an organization, known as the Pulaski County Medical Assistants Association, had been organized and functioning since April, 1949. Also two of the officers of the group, Mrs. Elizabeth D. Marsh, President, and Miss Charleen Hardeman, Co-Chairman of the Publicity Committee, kindly offered to assist in the organization of such a group on a State-wide basis. This offer has been gratefully accepted and plans are under way toward organization of the group at this time.

At least four States, and possibly more by now, have State-wide organizations of Medical Assistants. They are Kansas, Michigan, Oklahoma, and Missouri. Numerous other States have county or local organizations or they are now in the process of organization on a State level.

In regard to the purpose and objectives of the Pulaski County Medical Assistants Association the following is transcribed from the Constitution:

Section 1. To provide a means whereby each and every medical assistant in this locality may become closely associated and thereby work together for the common good of the Medical profession.

Section 2. To aid medical assistants with their medical problems such as:

1). Public relations.
2). Current medical economic trends.

Section 3. To provide a means of social entertainment among medical assistants.

This worthwhile group has done much for the Medical profession. They have helped us greatly in our fight against governmental control of medicine. They have sponsored instructional courses in Human Relations; Medical Terminology; Nursing Technique; Office Procedure and Management; Public Relations; Health Insurance programs and many others.

We of the Arkansas Medical Society are indebted to this fine group from Pulaski County for what they have done in their own organization and for their assistance toward forming a group for all the State. Each physician should lend his interest and effort in placing Arkansas on the list of States having an active Medical Assistants Association.—C. Lewis Hyatt.

★ Editorial ★

"DISEASES OF CIVILIZATION"

Guest Editorial

The benefits of civilization seem to carry a medical penalty. The proof is presumptive, not absolute. Idiopathic ulcerative colitis and peptic ulcers are excellent examples.

Exacerbations of ulcerative colitis tend to coincide with unpleasant life situations. In a speech to the American College of Physicians, Arkansas-Oklahoma Section, Dr. Walter Palmer described the case of a schoolboy who wanted to go to work; when told by his parent that he must go to college, he developed intractable colitis which waxed and waned, depending on the degree of parental pressure that was applied to force the patient to go to college. Admittedly, ACTH would probably be helpful in cases such as these, but would not correction of the environmental maladaption be more fundamental? In our enthusiasm to use modern drug therapy, there is a tendency to overlook the benefit that can derive from removing the patient from an unpleasant, stressful situation.

The successful executive with peptic ulcer will invariably complain of more epigastric distress during periods of tension and worry; away from business, on a vacation, symptoms may disappear despite a minimum attention to diet. Stress activates the adrenal glands. The natural Cortisone-like hormone stimulates the activity of the gastric acid forming glands. The increased acid output in turn exacerbates the peptic ulcer. The patient with peptic ulcer may not obtain relief with anti-secretory drugs and antacids unless he is removed from his noxious surroundings.

Perhaps the most common of all diseases of this group is the so-called irritable colon, characterized by achy or crampy abdominal pains, often with mild constipation or diarrhoea. Might not this reflect an emotional storm at the cortical level, drifting into the automatic centers of the brain; in turn, these centers may function in a somewhat disorderly fashion, leading their target organs, as the intestines, to function erratically. The resulting pain in the abdomen is not imaginary, but represents disordered muscle activity. It should be made clear to the patient that, although the ultimate cause of the pain is emotional stress, the pain is not in his imagination.

We cannot be sure of the relationship of hypertension, migraine, and other vascular diseases to tension.

Ultimately, although the stresses of civilization may play a contributory role in some of our more common diseases, and although they may be the chief perpetuating factor, it is remarkably difficult to re-arrange a person's environment or to relieve them of their sense of tension. The complexities of civilization prevent a simple solution.

Alfred Kahn, Jr., M.D.

Arkansas' annual Rural Health Conference in Little Rock was headed by the enthusiastic Ben Saltzman and showed considerable results.

At this meeting Arkansas physicians meet chiefly with those interested in Home Demonstration Clubs, Rural Health Committees of various county and state organizations and anyone particularly interested in the problem generally.

The forums conducted are of some value. However, the specific problems brought in by physicians and others in solution, offer the most fruit. Sometimes there are problems of discussion, sometimes of sanitation, sometimes of epidemiology and there are physicians there who can answer most of the questions.

The rural health problem should be shouldered, also, by each county medical society, which can organize meetings, get moderators like Ben Saltzman, and others, to lead, and to bring these rural workers face to face with the same physicians who are to be the ones to guide and implement their suggestions. The state meeting points the way, but the work has to be done in the field. Dr. Saltzman and his committee are to be commended for a hard and tedious task well done. With his predecessors, Henry of Little Rock, and Henry of Russellville, and others, he has built up a valuable medium of consultation with many civic and governmental groups.

Read the Journal of the AMA! We believe the Arkansas physician who does not take time out to read his official Journal is missing something. During the last eight months the format has been improved. It's simply easier to find what you want. There is no better source for the Washington scene than the page devoted to medical-political problems. It is singularly up to date and is the quickest source from which news can be obtained.

One other department will be mentioned in a field of many excellent departments. That field is "abstracts." Without question the abstracts of the medical literature both domestic and foreign are at their highest quality. The physician who doesn't read his AMA Journal is definitely the loser.

BRITISH LABOR FED UP WITH NATIONAL HEALTH SERVICE

A.M.A. Secretary, George F. Lull Says (Letter, July)

Dr. Blasingame of Wharton, Texas, called my attention to a very interesting editorial which appeared in the July 20 issue of New York Medicine. It was entitled: "Is England Returning to the Private Practice of Medicine?"

The editorial pointed out that as in the United States, British companies have to negotiate new contracts with labor unions and, as in the U. S., they have supplied so-called "fringe" benefits in the health and welfare field. "And what are these new fringe benefits in England?" the editorial asked, and then added:

"They are prepaid medical insurance plans which make it possible for the workers to go to private physicians of their own free choice and have the plan pay the costs of medical care. . . .

"Human nature being what it is, we now have the situation where the reaction has set in and the British workers prefer not to go to the National Health Service. The workers prefer to go to their own private doctors. They want free choice.

"The trouble is that they did not realize this until they surrendered their free choice. Now the unions find that they have to negotiate to get it back."

MONIES FOR MEDICAL SCHOOLS

The first 1954 distribution of unrestricted funds to the nation's 80 medical schools was made in July by the National Fund for Medical Education. These 1954 grants totalled $2,176,904.71, including $1,101,000 from the medical profession through the American Medical Education Foundation.

Each of the 74 four-year medical schools received $15,000 plus $25 per undergraduate medical student enrolled in the school. Each of the six two-year schools received $7,500 plus $25 per student. Added to these grants were gifts to individual doctors to designated schools.

NEW FILM CATALOG READY

The revised catalog of medical and health films now available from the A.M.A.'s Committee on Medical Motion Pictures may be obtained on request from the Committee. This booklet gives brief descriptions of more than 100 films.

ACADEMY ANNOUNCES NOTED PROFESSOR FOR 6th ANNUAL POST-GRADUATE ASSEMBLY

October 6 and 7, (with meetings at the Lafayette Hotel, Little Rock), has been selected for holding the two-day annual Fall Assembly of the Arkansas Academy of General Practice.

Professor-Doctor Narno Dorbecker from the University of Mexico has accepted and will talk on some phase of cardiology. He is Chief Radiologist at the National Institute of Cardiology and is a fluent speaker in English and French as well as Spanish. He has only recently returned from Bogota, where he delivered a series of lectures at the University of Colombia, S. A.

Another outstanding speaker is W. B. Hildebrand, President of the American Academy of General Practice who will be featured at a noon meeting of all participants.

Other speakers include faculty members from the medical schools of Tulane, Oklahoma, Cincinnati, and Washington University of St. Louis.

A strong delegation of members and visitors is expected at which all physicians of Arkansas are invited. Physicians are advised to watch for further circulars and announcements and to get reservations for October 6 and 7 as soon as possible.

The **Section of Industrial Medicine** at the University of Arkansas Medical School announces through its office of Post-Graduate Instruction, that a two-day course on Industrial Medicine will be given October 11-12 at the Medical School. This course has been approved for credit by the Arkansas Academy of General Practice. Further announcement will be made of this course through the mails.

COMING MEETINGS

October 6-7 — ARKANSAS ACADEMY OF GENERAL PRACTICE ANNUAL FALL CLINIC ASSEMBLY, Little Rock.

October 25-28—OKLAHOMA CITY CLINICAL SOCIETY (24th Annual Conference), Oklahoma City.

November 8-11, 1954—SOUTHERN MEDICAL ASSOCIATION, St. Louis, Missouri.

CONGRATULATIONS to John T. Herron, State Health officer, whose most recent ARKANSAS HEALTH BULLETIN has just reached our desk. That issue shows considerable vigor and some news to chew on!

Arkansas TRAVELING

And Clipping Bits Here and There

Gov. James F. Byrnes, speaking at a meeting of the South Carolina Medical Association—"Doctors must answer the misrepresentations of their critics. And the doctors of the state cannot hold themselves aloof from the life of the community and the state. They must, like all other citizens, take an interest in city, county, and state governments. They have great power and influence, and they should exercise it for their own good and the good of the people."

RE: MEDICINE vs. OSTEOPATHY

The bonding of the two professions without loss of identity that has been suggested by the Committee for the Study of the Relations Between Osteopathy and Medicine could, conceivably, make professional life easier for the doctors of medicine in the states where most of the cultists practice. In the other forty-four states, where osteopathy and its adherents are held in their proper perspective, such action would, indeed, constitute an unholy syzygy.—Nebraska State Med. Journal, August, 1954.

The personal affront from one doctor to another generally comes from a certain type. He is the small and narrow individual who in his own heart knows his shortcomings and feels he must resort to other measures to attract attention. Selfishness is his chief concern. He is also the chap who sees to it that the local newspaper reports that he attended the county medical society meeting and that he and his wife were invited someplace to dinner. He pushes to the front at every opportunity and then finds some way to let his community know about it. He is also the type whose feelings are easily hurt, and who is ready to complain of his competitors stepping on his toes.—Another quote from the Nebraska Journal.

RESOLUTIONS

WHEREAS, Darmon Artelle Rhinehart departed this life May 29, 1954, and

WHEREAS, as a practicing physician and roentgenologist he cherished and espoused the highest ideals of the medical profession, ever mindful of the rights and interests of the patient and the physician, and

WHEREAS, he was enthusiastic in the activities of Medical organizations, county, state, and national and in the various specialty societies.

Therefore, Be It Resolved, That the Arkansas Radiological Society adopt this resolution of respect to his memory.

"Those, who would give up essential liberty to purchase a little temporary safety, deserve neither liberty nor safety."—B. Franklin.

OBITUARY

FELTS, JAMES E., 96, died July 3, 1954, in Heber Springs. He had practiced in his home until his retirement three years ago.

Born in Izard county June 28, 1858, he was the son of John D. and Hannah Spraks Felts, one of the state's pioneer families. He attended Vanderbilt University School of Medicine and the Louisville Medical College graduating from the latter in 1881, he was the oldest living alumnus of that college.

A daughter and a son survive him. Burial was in the Heber Springs cemetery.

STELL, J. S., 65, Hot Springs, died July 31, 1954, at a local hospital. He had practiced medicine in Hot Springs for nearly 40 years, after graduating from Tulane University School of Medicine in 1917, and serving in World War I in the Medical Corps.

Dr. Stell was a Mason, a member of the American Medical Association, and the Arkansas Medical Society, and a past president of the Garland County Medical Society. He had been a member of the Board of Deacons at First Baptist Church at Hot Springs.

Besides his wife, Ruth Ross Stell, his survivors include one daughter, two brothers, and one sister. Burial was in Hot Springs.

BARNETT, JAMES RUSSELL, 41, Arkadelphia, died suddenly at Gurdon, Arkansas, July 7, 1954.

Dr. Barnett was a native of Little Rock and a member of the Presbyterian Church. He was a practicing physician in Arkadelphia for thirteen years, a member of the Clark County and Arkansas Medical Societies, the American Medical Association and the staff at the Clark County Memorial Hospital.

He graduated from the University of Arkansas School of Medicine in 1940 and served his internship at Charity Hospital in Shreveport.

Survivors include his wife, two daughters, Misses Judy and Barbara Barnett of Arkadelphia; his mother, Mrs. J. R. Barnett of Lonoke, and a sister, Mrs. Burney Whitfield of Lonoke.

Funeral services were held at Arkadelphia with interment in the Rose Hill cemetery.

BAKER, JOHNSON, J., 75, Magnolia City Health Officer, died July 25, 1954, at his home. He graduated from the old Memphis Hospital and School of Medicine in 1902.

He was born in Columbia County, September 30, 1878, the son of Josh and Methiah Baker. His family homesteaded here prior to the formation of Columbia County in 1854.

He was active in community affairs and in previous years had served as both city and county health officer.

Funeral services were held at the Central Baptist Church. Burial was in City Cemetery.

Survivors of Dr. Baker include his widow, Sally Cotton Baker, of the home, two daughters, and one son.

HOLLINGSWORTH, G. F., 52, Dyess, died at his cottage near Hot Springs July 21, 1954.

Dr. Hollingsworth operated the Dyess Hospital the last 12 years and was a member of the staff at Mississippi County Memorial Hospital at Osceola. He was a member of the Mississippi County Medical Society and the Arkansas and American Medical Associations.

After graduating from the University of Arkansas Medical School at Little Rock, Dr. Hollingsworth practiced medicine at Hampton seven years. From 1938 until 1942 he was director of the branch of the State Tuberculosis Sanatorium at Fort Smith.

He was a native of Hampton and was a Mason and a Methodist.

Survivors include his wife; a son, Jack Hollingsworth of Dyess; a daughter, Mrs. Johnny Anthony of Bearden; three brothers and a sister.

Funeral services were at Hampton Methodist Church. Burial was at Camp Ground Cemetery.

TUBERCULOSIS ABSTRACTS

A Review for Physicians

ISSUED MONTHLY BY THE NATIONAL TUBERCULOSIS ASSOCIATION

BED REST IN THE TREATMENT OF PULMONARY TUBERCULOSIS—

A Twenty-Year Follow-Up Study of 377 Patients

By ALBERT I. DeFRIEZ, M.D., WILLIAM E. PATTON, M.D., EDWARD J. WELCH, M.D., and THEODORE L. BADGER, M.D.

The New England Journal of Medicine, January 14, 1954

Recent advances in the treatment of pulmonary tuberculosis warrant a critical review of the place of bed rest in the treatment of this disease. Bed rest, of varying character and duration, has been the cornerstone of treatment for many years. New drugs and improved surgical technics have made a strict evaluation of the older methods of treatment necessary in order to have a therapeutic baseline by which the newer procedures may be judged. Today the treatment of even minimal tuberculosis without chemotherapy is unusual so the effects of bed rest **per se** can be determined only by a retrospective study such as this.

Since 1930 the Channing Home (Boston) has used strict bed rest as the basis of treatment, with additional forms of therapy as indicated. There has always been a conflict of attitudes toward the treatment of the tuberculous patient, necessitating a compromise between the maximum amount of rest needed by those acutely and chronically ill and the physiologic benefits of exercise for the normal body. This conflict still prevails and probably accounts for the wide variations in the regimens of rest advised.

The records of all patients admitted to the Channing Home for Tuberculosis from 1930 through 1944 were reviewed for this study. This institution is a 29-bed voluntary hospital founded in 1857 for the treatment of chronic disease in women. Since 1900, however, only patients with pulmonary tuberculosis have been admitted, and they, with few exceptions, are placed on strict bed

rest. When clinical signs of active disease are absent, when the sputum is converted and serial X-ray films show no change, bathroom privileges are allowed, then increasing activities. Eight weeks before discharge, patients are placed on exercise increasing by daily increments of five minutes, until, having reached four hours a day out of bed, they are discharged to continue treatment under the care of their physician at home.

All X-ray examinations of the lungs were reviewed, but those taken at the time of admission, six weeks later, four months after admission and at discharge were regarded as an index of progress for the study. These were evaluated in retrospect by a panel of three or more staff members. Following discharge chest films taken in the period up to five, six to ten, 11 to 15 and 16 to 20 years were compared to evaluate the patient's subsequent progress.

The incidence of relapse or progression of disease under sanatorium treatment and of relapse after discharge was selected as an index of the success or failure of treatment. No attempt was made to differentiate a "relapse" from a "progression." The few patients who signed out against advice did not significantly affect the results. Patients (53 of the 377 studied) who were granted bathroom privileges on admission had small lesions and were afebrile. Statistical analysis of this group revealed that it was justifiable to consider them with the main group of patients. During the period of this study 434 patients were admitted to the institution. Seven of these were never proved to have had active tuberculosis, 16 were transients and 34 were readmissions and were evaluated only on the basis of their original admission.

A total of 377 cases thus became available for study. Of these, 156 were transferred from the Channing Home to other sanatoriums. This group was included because, on review, it was apparent that their relapse rate did not differ significantly from that of the 221 patients who remained at the Channing Home during their treatment. Follow-up data and statistical analyses were based on the total hospitalization of 377 patients. The median age of the patient population was 28.3 years. The average hospital stay for all cases was 15.4 months. Patients given thoracoplasty and pneumothorax had a long period of hospitalization (a mean of 22.5 months and 18 months respectively) probably because at the time of admission they had sufficiently acute or advanced disease to warrant extended bed rest before surgery.

Advanced disease accounted for 76 per cent of all admissions while 16 per cent were classified as having minimal disease. The remaining eight per cent were patients whose chest films could not be classified for a variety of reasons.

All living patients were followed for a minimum of five to a maximum of 20 years; 58 per cent were alive at the end of the follow-up period, and 23 per cent had died of tuberculosis. The term "relapse" is used to designate any patient who showed a progression of disease after leaving the institution, whatever the interval after discharge. There was a high mortality from tuberculosis among those who relapsed. Of 95 patients who relapsed 31 per cent finally recovered, and six per cent died of causes other than tuberculosis. The others are dead of tuberculosis, have relapsed again or are still on restricted activity.

The highest annual relapse rate occurred during sanatorium treatment due to the 48 patients, many of them severely ill when admitted, who died in the institution. The "cumulative relapse rate" reveals that, of 100 persons, 50 had either progressed in the sanatorium or relapsed after discharge by the end of 20 years. The cumulative relapse rate corrected for the 48 patients who died in the institution is 42 per cent for the 20-year period.

No matter what the stage of the tuberculosis was or what treatment applied, the cumulative relapse rate is high. The 20-year cumulative relapse rate is 33 per cent for patients treated with strict bed rest plus thoracoplasty, 39 per cent for patients with minimal tuberculosis treated with strict bed rest and 54 per cent for patients with moderate disease treated with strict bed rest. The relapse rate for advanced tuberculosis treated by every available means was 56 per cent.

Bed rest must be considered a specific form of therapy along with other procedures such as pneumotherapy, chemotherapy and definitive surgical technics. In this study specific treatments are hardly comparable with each other on a strictly statistical basis; but in all forms of therapy there is reason to be dissatisfied with the subsequent high rate of relapse. A recent evaluation of modified bed rest in minimal tuberculosis, showed that the younger the patients, the more newly acquired the disease and the greater its extent, the more likely it was to relapse over a period of time. The present study indicates that **strict bed rest** was no more dependable than **modified** rest as treatment for minimal tuberculosis. It seems preferable to utilize both chemotherapy and occasionally surgery, in addition to bed rest in minimal disease that is so unpredictable and so prone to relapse.

The real effect of bed rest is still unknown, yet its value in active stages of tuberculosis remains widely accepted. It may be possible to shorten the period of bed-rest when used with anti-tuberculous drugs. Greater emphasis on indoctrination of the patient will be necessary, and rehabilitation will be begun early in the long-term chemotherapy. Meanwhile, while new therapies are being explored, bed rest should remain the starting point of management. Finally it should be noted that the unequivocal value of anti-tuberculous drugs makes treatment of active tuberculosis by bed rest alone hardly justifiable. The problem of the future will be to determine how much bed rest, strict or modified, is advisable in addition to drug therapy in the management of each patient.

PERSONALS AND NEWS ITEMS

Mr. Paul Schaefer, executive secretary, spoke to the Fort Smith Rotary Club, July 28, on legislation affecting the medical profession. He also spoke to the Fort Smith Council of Social Agencies, August 9, on the rural health program of the Arkansas Medical Society.

Mr. Schaefer also represented the Society in a conference in Washington on August 6. His conference was with Arkansas representatives on the Social Security Extension Bill.

Billy Sammons opened an office for general practice in Fayetteville August 1. He is a native Arkansan and has returned from a year's sea duty with the U. S. Navy.

O. W. (Bill) Davenport, a graduate of the University of Arkansas School of Medicine, and a native of Oklahoma, has opened offices at Bauxite. His boyhood home was Clinton, Arkansas.

Charles H. Kimbro, Tillar, announces his retirement after 53 years of practice in Drew County of which he is a native.

He studied medicine at the University of Arkansas Medical School and got his degree in 1903 at Tulane University Medical School at New Orleans.

He began his practice at Florence and practiced at Selma seven years before moving to Tillar, where he has practiced since 1915.

Dr. Kimbro found time to take an active voice in civic affairs. He is a former president of the Tillar School Board and has been a director of the Citizens Bank of Tillar more than 30 years.

For 26 years he has been superintendent of the Sunday School at First Baptist Church, where he is a deacon and sings in the choir. He is a member of the Southeast Arkansas Medical Society and the Arkansas Medical Society.

George W. Parsons, Texarkana, was a patient in a Rochester, Minnesota, clinic in August.

John H. Williams, Marshall, was hospitalized in a Little Rock Hospital in early August with a heart attack.

Louis A. Draeger has moved his office into new quarters at Danville.

Yell County Hospital (Do we remember the Free State of Yell?) opens its doors in Danville about the first of November.

When the National Association of Coroners met in Little Rock August 17-19, 1954, the program included a galaxy of Arkansas Physicians: Lloyd Wilbur, A. Nettleship, E. H. Crawfis, Howard A. Dishongh, M. J. Kilbury, Sr., all of Little Rock, and R. B. Robins, Camden. S. A. Thomas, deputy chief Medical Division C.A.A., and an outstanding alumnus of the University of Arkansas Medical School, took part on the program.

Eva F. Dodge, Little Rock, has been elected secretary of the Pan-American Medical Women's Alliance.

Byron Z. Binns is planning an eight-room clinic for his use in Eudora. It will be ready this fall.

Charleston residents have a new medical clinic since July 8. W. C. Hensley, a native Arkansan, opened offices for a general practice there.

The marriage of Paul L. Mahoney, Jr., Little Rock, to Elizabeth Ann McGinnis of Panama City, Florida, was a social event of the month of August.

The announcement of the engagement and approaching marriage of Thomas Ewell Cochrane, Jr., North Little Rock, was made in August. The bride to be is Ann Davis, Topeka, Kansas. Dr. Cochrane begins a three-year residency in Kansas City in September.

A. E. Thorne, Osceola, has moved his offices to Van Buren where he will be associated with G. K. Patton in a general practice.

J. Troy Payne, native of Leachville, has moved to Blytheville and has joined the staff of the Walls Hospital.

Henry H. Good, Jr., returned to his home town from service in Germany with the army and opened an office in England in July.

Terry J. Swaim and F. M. Wilson have opened a clinic together in Cotton Plant.

J. H. Scroggin has moved offices from Fordyce to England.

John W. Redman opened an office in Van Buren, September 1.

Paul Hinds has returned from service in the Navy and opened an office in Danville.

Roy I. Millard had a two weeks' post-graduate course in fractures at the Cook County Hospital this summer.

V. H. Marques was appointed city health officer by the Lake Village City Council last July.

John Alfred Webb, a native of Stone County, has returned from Army service and opened his office for a general practice in Mountain View.

Robert K. Setzler, Bauxite, has accepted a position with the U. S. Indian Service and has moved to Albuquerque, New Mexico.

H. W. Thomas, Dermott, addressed the Rotary Club of that city, July 8, on "Changing Aspects of Medical Service."

Austin C. Smith has opened a clinic in Huntsville recently. He is a native son of Madison County.

G. J. Floyd, a native of Nashville, opened offices in Murfreesboro in July after serving with the Navy for two years.

Rueben L. Chrestman, Jr., has returned from a tour of duty with the Army in Tehran, Iran, and reopened his offices in Helena.

James W. Freeland moved to Star City in July and opened offices there. He will be in general practice and has recently completed work at the Philadelphia Naval Hospital.

Gordon Stewart has returned to Mount Ida and is renovating offices there for his use in a general practice.

William Knight, Fort Smith, and Eugene Crawley, Little Rock, held a Crippled Children's Clinic in Rogers August 13.

PROCEEDINGS OF SOCIETIES

Clark County Medical Society

The following resolutions and motions were passed at last meeting of the Clark County Medical Society on August 3, 1954.

I. Re: Premarital examinations.

In addition to a standard Serologic test for Syphilis a minimum examination should be performed on all premarital examinations. This minimum physical examination should cover at least the mouth, throat, chest, Cardiovascular system and genitalia.

Charges: $5.00—STS and Exam.
$3.00—Exam.

II. The Clark County Medical Society will participate in the seventh annual Diabetes Detection Drive November 14-20. H. D. Luck was appointed chairman of a committee formed to expedite on participation.

III. The following rates for house calls outside the city limits were approved.

Up to six miles—fifty cents a mile plus four dollars.

Up to six miles—one dollar mile.

All members are urged to conform with this schedule.

H. D. Luck, Secretary.

Dramamine's® Effect in Vertigo

Dramamine has become accepted in the control of a variety of clinical conditions characterized by vertigo and is recognized as a standard for the management of motion sickness.

Vertigo, according to Swartout, is primarily due* to a disturbance of those organs of the body that are responsible for body balance. When the posture of the head is changed, the gelatinous substance in the semi-circular canals begins to flow. This flow initiates neural impulses which are transmitted to the vestibular nuclei. From this point impulses are sent to different parts of the body to cause the symptom complex of vertigo.

Some impulses reach the eye muscles and cause nystagmus; some reach the cerebellum and skeletal muscles and righting of the head results; others activate the emetic center to result in nausea, while still others reach the cerebrum making the person aware of his disturbed equilibrium. *Vertigo may be caused by a disease or abnormal stimuli of any of these tissues involved in the transmission of the vertigo impulse, including the cerebellum and the end organs.*

A possible explanation of Dramamine's action is that it depresses the overstimulated labyrinthine structure of the inner ear. Depression, therefore, takes place at the point at which these impulses, causing vertigo, nausea and similar disturbances, originate. Some investigators have suggested that Dramamine may have an additional sedative effect on the central nervous system.

Repeated clinical studies have established Dramamine as valuable in the control of the symptoms of Ménière's syndrome, the nausea and vomiting of pregnancy, radiation sickness, hypertension vertigo, the vertigo of fenestration procedures, labyrinthitis and vestibular dysfunction associated with antibiotic therapy, as well as in motion sickness.

Any of these conditions in which Dramamine is effective may be classed as "disease or abnormal stimuli"* of the tissues including the end organs (gastrointestinal tract, eyes) and their nerve pathways to the labyrinth.

Dramamine (brand of dimenhydrinate) is supplied in tablets of 50 mg. and liquid (12.5 mg. in each 4 cc.). It is accepted by the Council on Pharmacy and Chemistry of the American Medical Association. G. D. Searle & Co., Research in the Service of Medicine.

The site of Dramamine's action is probably in the labyrinthine structure.

*Swartout, R., III, and Gunther, K.: "Dizziness:" Vertigo and Syncope, GP *8*:35 (Nov.) 1953.

BOOK REVIEW

Practical Fluid Therapy in Pediatrics: Fontaine S. Hill, M.D., Assistant Professor of Pediatrics, University of Tennessee College of Medicine, Memphis; Staff Member of the John Gaston Children's Hospital and the LeBonheur Children's Hospital. Pp. 275, 1954. W. B. Saunders Company, Philadelphia. Price $6.00.

This book is organized into three sections; first presenting basic physiological information regarding fluids and electrolytes, then various abberations encountered with illustrative case histories; and finally a discussion of the techniques employed for diagnostic and therapeutic use in problems of fluid and electrolyte therapy in pediatric patients.

This book will provide excellent reading and can be recommended for both pediatricians and general practitioners as a guide and reference when dealing with the pediatric patient who requires serious consideration of fluid and electrolyte status in a number of illnesses.—J.R.D.

Fifty Years of Medicine: Lord Horder. Lecturer: Royal Institute of Health and Hygiene. Seventy pages. Philosophical Library, Inc. New York. $2.50.

These "expanded" lectures consist of some personal anecdotes of a physician interested in organizations of physical medicine in Britain. It adds nothing to science and little to history.

Emergency Treatment and Management: Thos. Flint, Jr., M.D. Director, Division of Industrial Relations, Permanente Medical Group, Oakland and Richmond, Calif. Chief, Emergency Department Permanente Medical Group, Kaiser Foundation Hospital, Richmond, Calif. Pp. 303, 1954. $5.75. W. B. Saunders Company, Philadelphia.

This 300-page book presents in a fairly complete, but very concise form, most conditions with which a physician may be confronted as an emergency.

The indexing, topic arrangement, and cross-references are such that any given emergency condition can be found and its signs, symptoms, and treatment can be reviewed very quickly, in most cases within one to three minutes.

The subject-matter adheres literally to the book title; i.e., emergency treatment, and it does not outline, describe, or recommend methods or types of treatment beyond the emergency phase.

The conditions covered include emergencies associated with organic and infectious diseases, injuries, and a large and excellent section on poisonings.

This book can be recommended for use, primarily by general practitioners, as a quick office and hospital emergency treatment guide and could even be useful to have in the physicians bag for ready and reliable reference away from office or hospital.—W.J.B.

The Physician and His Practice, edited by Joseph Garland, M.D., Editor New England Journal of Medicine, Eighteen contributors. 270 pages. Little, Brown, and Company, Boston, Massachusetts. Publication date, September, 1954. $5.00.

The polished editorship of Dr. Garland alone would make this book worth reading. In its covers he has assembled an unhurried consideration of the facts of the practice of medicine by many medical leaders and thinkers. The book makes good reading and reflection. It is especially valuable to interns and young physicians. Older practitioners will find in it a haunting nostalgia. The diverse thoughts of our better medical leaders are given and makes this a book to keep.

U. C. MEDICAL CENTER LIBRARY
OCT 30 1954
San Francisco, 22

OCTOBER 1954

THE JOURNAL OF THE ARKANSAS MEDICAL SOCIETY

OL. LI No. 5

FORT SMITH, ARKANSAS

consider
ILOTYCIN
(ERYTHROMYCIN, LILLY)
FIRST

...because its antibiotic spectrum is unexcelled

'Ilotycin' is effective against over 80 percent of all bacterial infections; yet the bacterial balance of the intestine is not significantly disturbed.

Lilly

produces contractions

'clinically identical to normal, strong, prolonged labor'

PITOCIN®

AN OXYTOCIC OF CHOICE

PITOCIN is widely used in obstetrics because of its physiologic effect on uterine musculature. In addition, the fact that it is notably free from vasopressor action is often a significant advantage. Intravenous administration of diluted **PITOCIN** in emergencies makes possible ready control of dosage and response.

PITOCIN is valuable in treatment for primary and for secondary uterine inertia, for postpartum hemorrhage due to uterine atony, for the third stage of labor, for induction of labor, and during cesarean section to facilitate suturing the uterine wall.

*Kaufman, R. H.; Mendelowitz, S. M., & Ratzan, W. J.: *Am. J. Obst. & Gynec.* 65:269, 1953.

PITOCIN (oxytocin injection, Parke-Davis) is supplied in 0.5-cc. (5-unit) ampoules, and in 1-cc. (10-unit) ampoules, in boxes of 6, 25, and 100. Each cc. contains 10 international oxytocic units (U.S.P. units).

MEDICAMENTA VERA

Parke, Davis & Company

DETROIT, MICHIGAN

THE

Journal

OF THE

Arkansas Medical Society

Owned by

THE ARKANSAS MEDICAL SOCIETY

And Published Under Direction of the Council

FOUNT RICHARDSON, M.D., Editor

316 West Dickson Street — Fayetteville, Arkansas

MR. PAUL C. SCHAEFER, Business Manager

215 Kelley Bldg. — Fort Smith, Arkansas

The Advertising policy of this JOURNAL *is governed by the rules of the Council on Pharmacy and Chemistry of the American Medical Association.*

EXCLUSIVE PUBLICATION—Articles are accepted for publication on the conditions that they are contributed solely to this JOURNAL.

COPYRIGHT, 1954—By The JOURNAL *of the Arkansas Medical Society.*

NEWS—Our readers are requested to send in items of news, also marked copies of newspapers containing matter of interest to the membership.

OFFICERS OF THE ARKANSAS MEDICAL SOCIETY

W. R. BROOKSHER, President ..... Fort Smith
L. H. McDANIEL, President-Elect ..... Tyronza
T. P. FOLTZ, First Vice-President ..... Fort Smith
ELDON FAIRLEY, Second Vice-President ..... Wilson
R. H. WHITEHEAD, SR., Third Vice-President ..... DeWitt
J. J. MONFORT, Secretary ..... Batesville
DANIEL H. AUTRY, Treasurer ..... Little Rock
T. DUEL BROWN, Speaker, House of Delegates ..... Little Rock
C. C. LONG, Vice-Speaker ..... Ozark
MR. PAUL C. SCHAEFER, Executive Secretary
215 Kelley Bldg., Fort Smith

COUNCILORS

First District—JOE VERSER ..... Harrisburg
Second District—HUGH R. EDWARDS ..... Searcy
Third District—J. MAX ROY ..... Forrest City
Fourth District—L. K. HUNDLEY, Chairman ..... Pine Bluff
Fifth District—D. E. WHITE ..... El Dorado
Sixth District—HARRY E. MURRY ..... Texarkana
Seventh District—H. KING WADE, JR. ..... Hot Springs
Eighth District—H. ELVIN SHUFFIELD ..... Little Rock
Ninth District—FOUNT RICHARDSON ..... Fayetteville
Tenth District—J. M. KOLB ..... Clarksville

VICE-COUNCILORS

First District—WAYNE WORKMAN ..... Blytheville
Second District—JOHN SNEED ..... Conway
Third District—J. P. WILLIAMS, JR. ..... Brinkley
Fourth District—H. W. THOMAS ..... Dermott
Fifth District—GEORGE BURTON ..... El Dorado
Sixth District—CHARLES YARBOROUGH ..... Texarkana
Seventh District—RANDOLPH ELLIS ..... Malvern
Eighth District—ROBERT D. JONES ..... Little Rock
Ninth District—LEE A. DEAN ..... Rogers
Tenth District—LOUIE A. WHITTAKER ..... Fort Smith

Notice on Form 3578-P to be sent to the Arkansas Medical Society, 215 Kelley Building, Fort Smith, Arkansas. Published monthly under direction of the Council, Arkansas Medical Society, at Fort Smith, Arkansas. Vol. 11, No. 5. Subscriptions $3.00 a year. Single copies, 50 cents. Entered as second-class matter, Sept. 23, 1947, at the post office at Fort Smith, Arkansas, under the Act of Congress of March, 1879. Acceptance for mailing at special rate of postage provided for in Section 1103, Act of October 3, 1917, authorized August 1, 1918.

• SPECIAL FEATURES

Committee on Cancer Control 105
What Is Being Accomplished By Adrenalectomy 106
Setting Fees in Insurance Cases 110
Medical Ethics 113
Pulmonary Embolism 115
National Nurse Week 120
Coming Events 120
Medical Assistants Meeting 130

• FEATURES

Editorial 121
Arkansas Traveling 122
Obituary 124
Tuberculosis Abstracts 125
Personals and News Items 127
Proceedings of Societies 128
Auxiliary News 130

The JOURNAL
OF THE ARKANSAS MEDICAL SOCIETY
PUBLISHED MONTHLY UNDER DIRECTION OF THE COUNCIL

Vol. LI October, 1954 No. 5

Committee on Cancer Control

C. A. ARCHER, Chairman, Conway

LUNG CANCER

The interest of the public has been activated in recent months concerning pulmonary malignancies, especially by the suggestion of the casual effects of cigarette smoking. Recent reports indicate that there is a real increase in the incidence of the lesion. It is likewise becoming more apparent that the greatest opportunity for improving results in the treatment rests with detection in the asymptomatic stage. The onset of symptoms all too often indicates extension beyond the hope of surgical removal of the involved segment. Routine chest roentgenograms will frequently provide the suggestion of the presence of malignancy if they do not actually provide the diagnosis. In cases of doubt, resort must be had to bronchoscopy and the use of smear cytology. Exploratory thoracotomy is becoming more prevalent with the fuller understanding that it may be accomplished with no greater risk than will attend exploratory laparotomy. The conscientious physician will suspect malignancy, seek to prove or disprove its presence, and thus contribute toward an increase in the over-all curability of this dread disease.

WHAT IS BEING ACCOMPLISHED BY ADRENALECTOMY

JAMES W. HEADSTREAM and JAMES T. WORTHAM
From the Departments of Surgery and Medicine, University of Arkansas School of Medicine

Surgery of the adrenal glands is done for two purposes. One is to remove neoplasms of these structures and the other is performed to abolish functional activities which are harmful to the individual.

The evolution of adrenal surgery has been rather rapid in the recent past. This has been brought about because of the development of substitutive substances for the maintenance of life in the absence of adrenal glands. Other important developments have been valuable diagnostic procedures for visualization and for the assay of adrenal function, and improved surgery of the adrenals.

The adrenal cortex develops from the mesodermal cells in the region of the genital ridge. These grow to enclose the cells of the sympathetic nervous system, derived from the ectoderm to form the adrenal medulla.

The clinical effects of hyperfunction of the medullary portion are chiefly vasopressor in type.

In adrenal cortical hyperfunction there is an elaboration of androgens, estrogens, and corticoids of which cortisone is one. Cortisone has some effect of nearly every tissue and is the one adrenal steroid which is vital to life. Sodium and water retention are influenced by desoxycorticosterone acetate (doca). Diabetes and nitrogen loss is produced by cortisone. Nitrogen gain and somatic growth is promoted by testosterone. Masculinization or feminization is brought about by depression of gonadal function, by androgens and estrogens, depending on which is in excess.

Tumors of the Adrenal Medulla

Sympathicoblastoma, or neuroblastoma, is the more frequently seen tumor of the adrenal medulla. They are extremely malignant, occur most frequently in infancy and childhood and rate with seriousness to the renal embryomas of Wilms. They are frequently discovered only when a non-tender abdominal mass is observed. An excretory urogram will usually show displacement of the kidney. Removal by transperitoneal approach followed by irradiation is the recommended treatment but is generally unsatisfactory.

Case I

J. A., 3-year-old white female, fell striking the upper abdomen. On examination there was a definite mass noted. Pyelograms revealed a slight displacement of the right kidney. A right adrenal tumor and kidney was removed because of kidney invasion, followed by X-ray therapy. Died six months later with extensive metastases. Pathology —Neuroblastoma.

Pheochromocytomas are tumors of the pheochrome cells of the sympathetic system. They are not frequent, but are of unusual interest because when recognized and properly treated will result in cure of a hypertensive patient. About 80% of these tumors occur in the adrenal. The remaining 20% occur mostly in the abdominal sympathetic ganglia and a few have been reported in the thorax. 16% may be multiple and rarely have more than two been reported in one patient. 9% of them are reported as malignant.

Two hormones have been isolated from pheochromocytomas; Epinephrine and Norepinephrine. Both substances cause elevation of the systolic blood pressure but differ in other respects. Epinephrine causes little change in diastolic pressure, a decreased peripheral resistance, an increased cardiac output and tachycardia. Norepinephrine causes elevation of diastolic pressure and increased peripheral resistance and usually bradycardia.

The symptoms ordinarily seen are those of either paroxysmal or persistent hypertension. The diagnosis of pheochromocytoma, as with all disease is dependent on the physician's awareness of the symptom complex. During palpation sometimes an attack may be elicited.

Certain pharmacological release tests are of definite diagnostic value. Histamine and mecholyl given in a normotensive phase results in a striking hypertensive response. Adrenolytic or sympatholytic agents, as benzodioxane, dibenamine or regitine are useful diagnostic means in the sustained hypertensive. Here they reduce the blood pressure in tumor cases exclusively, with an accuracy of 98%.

After the presence of the tumor has been determined pharmacologically, the tumor may be localized by urograms and retroperitoneal air insufflation.

Regitine administered a few hours before and during the operation has greatly increased the safety with which the tumor may be removed.

Case II (Diagnosed by Doctors P. R. Anderson, Joe Reid and Lewis Tillery, Arkadelphia, Arkansas)

Read before the Seventy-eighth Annual Session, Arkansas Medical Society, Fort Smith, April 21, 1954.

L. J., a 43-year-old white male with 6-year history of paroxysmal hypertension. Definite response to sympatholytic drugs. Presacral air injection by Dr. Anderson revealed right adrenal tumor. Right adrenalectomy with excellent results. Pathology—Pheochromocytoma.

Cortical Tumors

1. Tumors with no recognizable hormonal changes in the patient.
2. Tumors with hormal changes.
   A. Adrenogenital
   B. Adrenocorticoid (Cushing's type)
   C. Mixed

Non-hormonal tumors of the adrenal cortex are slow growing, painless enlargements, most often malignant. They are recognized by their size and by displacement of other viscera by X-ray examination. Recovery after removal of these tumors is the rule as many have no metastases.

Hormonal Tumors of Adrenal Cortex

In those with androgenic effects, virilism results from these benign or malignant tumors which occur most often in young individuals. Characteristic findings are abnormally rapid skeletal growth, well developed musculature, deep voice, precocious development of pubic hair and growth of the penis or clitoris. In adolescent girls amenorrhea develops. Accompanying these changes, there occurs an elevation of the 17-ketosteroids estimation in the urine.

Case III

N. M., 4-year-old white female with rapid growth (appearing 8 years), precocious development of pubic hair and clitorial enlargement. 17-ketosteroids estimation 90 milligrams per 24 hours. Presacral air injection revealed right adrenal tumor. Right adrenalectomy with slow regression to normal. Diagnosis—Adenoma Malignum Adrenal.

Adrenal tumors with excess estrogen are rare; less than 20 have been reported. They have occurred more often in adult males, less in children. Most are highly malignant neoplasms which produce mammary hypertrophy, gonadal strophy with impotence. Female children may have menstrual periods. Laboratory estimation of estrogens are unreliable as a diagnostic means but if elevated, is significant.

Adrenal Tumors with Corticoid Effects

The syndrome described by Cushing occurs with adrenal tumor as well as with bilateral adrenal hypertrophy. Adrenal tumors with Cushing's syndrome may be benign or malignant and occur most commonly in young women.

The distinguishing features of Cushing's syndrome are muscular weakness, atrophy of the skin, osteoporosis, hirsutism, insulin resistant diabetes and amenorrhea or impotence. The striking features are the "moon face," the "pig eyes," the purplish cutaneous striae and the "buffalo" type of obesity involving the head, neck and trunk while sparing the extremities. Many patients have psychosis.

Marked increased values of 17-ketosteroids may be encountered in the urine.

Case IV

P. M., 31-year-old white female with practically every sign and symptom of Cushing's syndrome including marked osteoporosis and psychosis. Had received electric shock therapy for psychosis with resultant collapse of two vertebrae. 17-ketosteroids moderately elevated. Presacral air injection revealed adrenal tumor which was removed. Other adrenal biopsied and found to be extremely atrophic due to inhibition from opposite hyperfunctioning tumor. No replacement therapy necessary. Patient returned to normal living.

The localization of adrenal pathology as to whether it is unilateral tumor or bilateral hyperplasia and the reduction of operative exposure to one adrenal is accomplished by retroperitoneal air insufflation through the presacral area.[1]

This is performed by local infiltration anesthesia between the anus and tip of coccyx with the patient in the lithotomy position. A No. 20 spinal needle is inserted anterior to the coccyx and sacrum for a distance of five to six cm. with a finger in the rectum to guide the needle and to prevent rectal perforation. The stylette is removed and tubing with luer lock attachment is connected to a 50 cc. syringe and a two-way stopcock. Aspiration is necessary to prevent intravascular injection. Eight hundred cc. of air is slowly injected in the adult with a proportionate amount in children. X-ray exposure using KUB technique is made one and three hours later. It may be combined with excretory pyelography or aortagraphy obtaining complete visualization of the adrenals and kidneys. The only untoward reaction is moderate transitory subdiaphragmatic discomfort in some cases.

Removal of Non-Neoplastic Adrenals

The results of operation in Cushing's syndrome are usually excellent and ordinarily all symptoms and signs soon disappear.

Partial bilateral adrenalectomy has been used for Cushing's syndrome associated with bilateral

hyperplasia with certain degrees of success but it has some pitfalls relating to the fragment of adrenal left. This remaining fragment may atrophy due to loss of blood supply or it may hypertrophy with a recurrence of the disease. It seems that with the present means of sustaining a totally adrenalectomized individual that partial adrenalectomy has lost its indications.

Case V

I. C., 38-year-old white female with Cushing's syndrome. 17-ketosteroids estimation elevated. Presacral air injection revealed bilateral adrenal hyperplasia. Bilateral adrenalectomy performed with excellent reversal of symptoms. Maintained with 37½ milligrams cortisone and 6 milligrams DOCA daily.

Bilateral total adrenalectomy has been successful in certain cases of hypertension, palliation of advanced carcinoma of the prostate and female breast and recently in diabetes with vascular disease.

The first successful total adrenalectomy was performed by Huggins [2] in 1945 but much difficulty was experienced in control of the adrenal insufficiency. With the availability of cortisone, adrenalectomy has been re-investigated, with resulting indication for surgery in certain conditions and with good control of the adrenalectomized patient.

Malignant Hypertension

Malignant hypertensive patients without advanced renal failure can be markedly improved by bilateral total adrenalectomy. This is probably accomplished by elimination of the sodium and water retaining hormone (desoxycorticosterone acetate). Of course, this procedure is only indicated in those patients having hypertensive vascular disease who have failed to respond to other forms of therapy. The degree of renal function is important as a very high mortality can be expected in the severe renal insufficiency group of patients.[3]

Carcinoma of the Prostate

Advanced carcinoma of the prostate is known to respond well to bilateral orchidectomy and estrogen therapy for a variable period of time.

It is thought that the relapsing cases after hormonal control are due to adrenal cortex hyperplasia as a result of stimulation by the luteinizing hormone from the pituitary with subsequent increased androgen secretion from the adrenals.

Bilateral adrenalectomy will remove the remaining source of androgen, and approximately 50% of the relapsing carcinomas of the prostate have been benefited from this procedure.

It has been found that large doses of cortisone, up to 300 milligrams per day for 60 days and decreasing doses thereafter, would completely suppress and produce atrophy of the adrenal cortex. Since the damaging element to be eliminated by removal of the adrenals is androgens, it is now felt that medical adrenalectomy can be accomplished by large suppressing doses of cortisone, with results equal to those obtained by surgical adrenalectomy.

So, at the present time we are depending more on medical adrenalectomy than surgical adrenalectomy in relapsing cases of carcinoma of the prostate.

The huge doses of cortisone are not without danger. Sodium retention and edema are not easily controlled by salt poor diet and mecurial diuretics are necessary. Two to three grams of potassium is often required per day as this element is rapidly depleted. The development of diabetes must be considered.

Carcinoma of the Female Breast

About 40% of patients with advanced breast cancer have significant objective remissions following bilateral adrenalectomy.

Since half of the cases do not show adequate response, very interesting studies as to the microscopic appearance of the breast lesion and its anticipation or response to adrenalectomy have been made by Huggins.[4]

The better differentiated adenocarcinomas and papillary carcinomas showed a high instance of response to adrenalectomy, while the more anaplastic lesions in general did not respond.

It is believed that only the estrogen dependent breast tumor can be expected to respond to adrenalectomy. If there has been an improvement after surgical oophorectomy, then the advancing case can be expected to improve temporarily by further removal of another source of estrogen through adrenalectomy.

Large doses of cortisone may be an additional therapeutic approach and studies of this type are being conducted.

Diabetes with Degenerative Vascular Lesions

A most interesting and original investigation by Wortham [6] has been his belief that diabetics with advancing degenerative vascular lesions can be improved by bilateral adrenalectomy. Seven such cases have been performed and observed for six to twelve months. The more prompt responses

and more complete reversal of pathological findings in those cases with less severe grades of vascular pathology suggest that the procedure is indicated before the most advanced vascular changes have developed. There is a significant decrease in insulin requirement, and the loss of "brittleness" and lability suggest that the qualities of increasingly high insulin requirement and progressive lability are conditioned by abnormal adrenal cortical adaptive mechanisms. The concurrent improvement even in advanced pathology is also conditioned by abnormal adrenal cortical adaptive responses. A patient with marked elevation of the NPN and inability to concentrate urine will not show a satisfactory response as is the experience with adrenalectomy in hypertensive diseases.

The results of this procedure in diabetics can best be described by one of the case reports.

Case VI

The patient is a 23-year-old white married female. The onset of diabetes occurred at the age of 10 years when she had a rapid development of classic symptoms leading into acidotic coma. Within a few months of her initial regulation the diabetes became extremely brittle and poorly controlled, with frequent insulin hypoglycemic reactions. She has had five hospital admissions in diabetic coma. There has been a rapidly progressive increase in insulin requirements and regulation of the diabetes has never been achieved. In September of 1952, she began to notice rapid loss of vision in her right eye so that in a few weeks the vision was totally gone. About the same time she began to notice slow and progressive loss of vision in her left eye. She had had chronic generalized edema especially noticeable in the feet, legs, and face for several years. On numerous occasions over the past 3 to 4 years she has been told by her physicians that she had hypertension and albuminuria. Her menstrual history has always been considerably irregular with the cycle tending to be as long as 90 days in duration.

Blood pressure was 160/120 at the time of admission. There was vision only for a bright light in the right eye, where a well formed cataract was noted. The fundus of this eye was not visible. In the left eye the disc was described as 1 plus edematous with numerous small preretinal hemorrhages and a tortuosity of the vessels. A nonpitting chronic brawny edema of the legs and feet was noted and a 2 plus periorbital edema was present. The urine showed a few white and red blood cells and a 4 plus albuminuria. The Fishberg concentration test without glycosuria revealed a maximum concentration to 1.010. On March 4, 1953, after preparation with 300 milligrams of cortisone daily, bilateral adrenalectomy was done.

Results of the procedure began to appear quite rapidly. Her chronic edema began to recede. From her preoperative weight of 142 pounds, her weight stabilized after a few weeks to a constant 130 pounds with the patient being maintained on the same diet as preoperatively. The patient began to experience a convincing sense of well being. Twelve days postoperatively, it was noted that the edema around the disc had thinned out, the hemorrhages were being absorbed and there were no hemorrhages in the eye grounds. The diabetes became quite stabile and was closely regulated with 30 units of insulin daily. The eventual maintenance dose of cortisone proved to be 37.5 milligrams daily.

Two months after surgery a note was made that there had been a gradual improvement in the fundus picture all along and in the right eye which was able to see only bright light before the surgery; it was now noticed that a massive vitreous hemorrhage was gradually clearing. The vision had markedly improved to the point that the patient could read and attend movies as she had previously enjoyed doing.

After adrenalectomy the patient's menstrual periods became absolutely cyclic and ovulatory. She became pregnant three months after surgery. No disruption of her improvement occurred but it was necessary to increase cortisone maintenance to 50 milligrams daily. She aborted spontaneously during the 11th week of gestation. Her ability to concentrate urine to a 1.019 specific gravity in contrast to 1.010 preoperatively was noticed.

The patient is now working and continues to do well.

Medical Management Incident to Adrenal Surgery

An improved understanding of adrenal physiology and the availability of steroid hormones, especially cortisone and desoxycorticosterone acetate have revolutionized the management of patients after adrenal operations.

It has been a rule with us to over-treat the patient before surgery, as if insufficiency were certain to develop postoperatively, and to slowly withdraw the medication after surgery.

Three hundred milligrams of cortisone are administered daily for three days prior to and the day of surgery. This is gradually reduced over a five- to six-day postoperative period according to the sodium, potassium and eosinophil count. In

insufficiency the potassium is high, sodium low, and the eosinophil count high. It should be around 200 or below on maintenance therapy.

Most of the bilateral adrenalectomized patients are maintained on 25 to 50 milligrams of cortisone by mouth per day. In hot weather additional salt is ingested.

Technique of Adrenalectomy

The posterolateral approach with the patient in the lateral position commonly employed in kidney operations gives much the best exposure. The 12th rib is resected and incision made through the rib bed. The adrenal is easily located between the upper pole of the kidney and the diaphragm. A cleavage plane between kidney and adrenal and diaphragm is developed. A branch from the inferior phrenic is ligated and then the gland is easily depressed in good view.

If the operation is bilateral the wound is closed, the patient turned in the same position on the opposite side, redraped and the adrenal removed.

Braided wire sutures are used for closure in a very rapid manner by placing through-and-through sutures with exception of the skin while the patient is on the kidney elevator and then tied when the elevator is flattened.[5]

The wire sutures are considered essential since healing is somewhat delayed by cortisone therapy. No hernias have been experienced.

Summary

A brief review of the indications and what is being accomplished by adrenal surgery is presented.

Much can be offered the patient with a hormonal adrenal tumor.

Bilateral adrenalectomy is still in an experimental stage and thoughtful consideration must be given to the situation, by balancing the disease to be relieved or palliated, with the certainty of continued hormonal replacement.

References

1. Headstream, J. W., and Ruff, T. E.: Perirenal Air Insufflation by the Presacral Technique, Trans. of the South Central Section of Am. Urol. Assn., 1952.
2. Huggins, C., and Scott. W. W.: Bilateral Adrenalectomy in Prostatic Cancer: Clinical Features and Urinary Excretion of 17-ketosteroids and Estrogen, Ann. Surg. 122: 1031-1041, 1945.
3. Harrison, J. H., and Thorn, George W.: A Study of Bilateral Total Adrenalectomy in Malignant Hypertension and Chronic Nephritis, J. Urol. 67: 405, 1952.
4. Huggins. C., and Thomas L-Y DAO: Adrenalectomy and Oophorectomy in Treatment of Advanced Carcinoma of the Breast, J.A.M.A. 151: 1388 (Apr. 18), 1953.
5. Murry, J. W., and Headstream, J. W.: A Rapid Method for Closure of Lumbar Incisions in Surgery of Kidney, Adrenal and Upper Ureter. (Read at 1953 Meeting of South Central Section, American Urological Association, Kansas City, Mo., to be published.)
6. Wortham, J. T., and Headstream, J. W.: The Effects of Bilaterial Total Adrenalectomy in Diabetics with Advanced Vascular Disease, Third Annual Report on Stress, 1953; Selye and Horava, Acta Publishers.

SETTING FEES IN INSURANCE CASES

MR. C. L. STINNET, El Dorado
Personnel Managers Association of Arkansas

I have been asked to address this Public Relations Institute as a member of the Arkansas Personnel Managers' Association, which is representative of industry in the State of Arkansas. For some time, the members of the Association have felt the need for them and the medical profession to reach a better understanding of one another's problems concerning group hospital, surgical and medical insurance.

Accordingly, the officers of the Arkansas Medical Society met at dinner meetings with the members of the Personnel Managers' Association here in Little Rock in May, 1953, and again in July, 1953. During these meetings the doctors and personnel men frankly discussed those things being done by doctors and hospitals that were adversely affecting group insurance programs. We talked about how these so-called abuses tend to increase the cost of group insurance; how increased costs affect the attitudes and pocket books of employees and employers in this State. Considered also was the possibility that industry might ultimately be priced out of the group insurance field unless the doctors and the hospitals review their practices carefully and take such steps as are necessary to decrease the liability burdens against insurance programs. These alleged offenses are by no means limited to our State. On the contrary, this is a national problem with deep implications, which seriously threatens the reputation and well-being of the medical profession, clinics, and hospitals throughout America.

Address before Arkansas Medical Society—Public Relations Institute, October 31, 1953, Marion Hotel, Little Rock, Arkansas.

I am told that the cooperative efforts between the Arkansas Medical Society and the personnel people in reaching mutual understanding on this problem is unique from a national point of view. Members of the Personnel Managers' Association deeply appreciate the cooperative attitude that the doctors have taken in response to their suggestions. Members of our group realize that we should have met with the medical profession much sooner on this problem than we did. We also know that the medical profession did not have a clear understanding of what personnel and insurance people were thinking, and that the doctors and hospital administrators need more information on the limitations and extent of coverage provided by the numerous companies which represent Arkansas industry. Many of the so-called insurance abuses by the medical profession, therefore, can be charged in part, at least, to lack of communication between group insurance administrators, the doctors and physicians, and hospitals. We believe that in the future the lines of communication will remain open.

The inter-relation of the public and those who provide medical services is extremely complex. Countless individuals and agencies are involved, and a multitude of personal factors in addition to economic consideration affect their relationships. The introduction of insurance into the industrial and medical scene further complicates the picture since the insurance companies are now parties of interest as well as the hospitals, the doctors, and the public. It seems to me that the very presence of insurance, whether it be an individual policy or a group insurance arrangement, has an impact on the patterns and practices formerly in effect, and tends to increase the demand for medical services in a number of ways.

I should like to cover my subject in the light of the following basic points:

I. The Changing Medical Market.
II. The Economic Facts Involved in the Changing Medical Market.
III. What the Doctors Can Do.

I. The Changing Medical Market

a. In 1952, the American people voluntarily increased their protection against the unexpected cost of hospital, surgical, and medical care to the highest point in the history of our country.

b. Almost 92 million people in the United States have hospital expense protection in one form or another. Mind you, this is nearly three out of five people in the entire population of the country.

More than 73 million people have surgical expense insurance. Approximately 36 million people have some type of medical expense insurance.

c. A recent nation-wide survey reveals that today 70% of all hospital income in the United States is derived from insurance benefits in one form or another.

d. Let's look at some facts about our own State:

1. 450,000 persons are covered by hospital insurance.
2. 376,000 persons are covered by surgical insurance.
3. 119,000 persons are covered by medical insurance.

Considering that our population is a little less than 2,000,000 in Arkansas, it is apparent that a substantial portion of our population is covered by the type of protection under consideration. This will grow as Arkansas becomes more industrialized.

II. The Economic Facts Involved in the Changing Medical Market

a. As I stated a moment ago, the inter-relation of the public and those who provide medical services is an extremely complex situation.

b. Don't you agree that **SERVICE** is uppermost in the public's mind when medical help is needed? If this be true, doesn't it follow that **SERVICE** must be tempered by the economic reality of each individual's ability to pay? Obviously, the individual's ability to pay is aided considerably by modern insurance programs. However, it seems exceedingly unfair for the existence of insurance to cause an upward scaling of fees, a practice which I am told is not unheard of.

Let us examine "ability to pay" as it relates to our State.

1. In 1952 total income in Arkansas was $1,795,000,000.00. This seems to be an impressive amount.
2. However, per capita earnings in 1952 were $951.00, a pleasant gain over the $512.00 of ten years ago, but still next to the last in the Nation.
3. Shouldn't the medical profession and the hospitals in Arkansas evaluate their

fees and services in the light of our local "ability to pay"?

c. Returning now to the National level, only ten years ago one in sixteen disabled persons were hospitalized; yet today that ratio has become one in eight—a 100% increase.

d. Only ten years ago the miscellaneous benefits (generally referred to as hospital special services) paid under the average insurance policy were equal to about one-half the hospital room benefits paid. In 1952, the cost of miscellaneous benefits, however, exceeded the amount paid for hospital room expense over two times. The reason for this may be that with the greater spread of hospital insurance, people want to go to the hospital for treatment. Perhaps doctors find that they can give better service if their patients are hospitalized; certainly they can give more treatments and treat more patients conveniently if they are all confined in one building. We recognize, however, that doctors are put on the spot by their patients who often insist on hospitalization because "the insurance company pays for it anyway."

e. Unquestionably, prepayment insurance plans have added materially to the financial stability of the medical profession. While great advances have been made in medical and hospital care, in part, as a result of this greater stability, there is a growing concern that the ability to pay for it is not keeping pace. The point I wish to make is this: If the public is educated to expect all the services available, whether or not they are necessary or even advisable, they will demand them. Are there ways to "ease the burden of cost" without adversely influencing the standard of care that must be maintained in the interest of the patient? I merely pose this question; it is for you to solve. Here are some economic facts:

1. Hospital insurance represents a small percentage of the **premium income** of private insurance companies which specialize in hospital, surgical and medical expense coverage — only about 20%.

2. Insurance companies underwriting this type coverage realize an extremely **narrow rate of profit**—two to three percent. Isn't this a slim margin for survival?

3. Medical, surgical and hospital insurance is becoming an increasing factor in the premium income totals of underwriters. Moreover, it is in the forefront of the attack on insurance by the socialists and the professional dogooders. Doctors, hospitals, employers, unions, and insurance companies must cooperate to insure the continuance of democratic prepayment medical programs.

III. What the Doctors Can Do

a. A basic point that should be understood by every medical man is that it was never contemplated by insurance companies, in determining the rate of premiums, that policyholders should be hospitalized either for the convenience of the doctor or the patient, or for the profit of the insured patient.

b. The excessive utilization of hospital benefits might be curtailed:

1. If patients were not admitted to the hospital for diagnosis only, particularly when the insurance does not provide for diagnostic work as such.

2. If complete work-up were done before patients are admitted to the hospital rather than after admission.

3. If procedures that can be performed as well at home or in the doctor's office were not performed in the hospital.

4. If prescriptions of drugs and medications for use in the hospital were limited in quantity to the period of hospitalization.

5. If unnecessary laboratory tests were not performed.

c. As medical insurance coverage is broadened in an attempt to keep pace with increasing hospital and medical charges, insurance rates increase proportionally. If insurance rates continue upward, it is not unlikely that a serious reaction may occur, forcing those who can't pay, but want the best medical and hospital services available, to look elsewhere for payment of these services. It will probably be Uncle Sam to whom people will look. This might result in Socialized Medicine, and there are a lot of supporters of that

concept in our country today. You doctors don't want it, industry doesn't want it, insurance companies don't want it—but the medical profession must perk up and take notice of the possibilities, and put their shoulder to the wheel to change this kind of thinking in America.

IN CONCLUSION, I would like to point out that some of the facts contained in my remarks relate to conditions on a nation-wide basis. I am sure that many of the abuses indicated by these facts are not typical of the medical and hospital people of Arkansas. Unfortunately, most of the other states do not have the cooperative spirit demonstrated between the doctors and the representatives of their state. While we may have a little sweeping to do before we have a completely clean house, we have made remarkable progress in understanding, and as I stated before, we are setting an example for all the states to follow.

MEDICAL ETHICS*

RODGER DICKINSON, De Queen

Medical ethics—what is medical ethics? I am sure I don't quite know, so you see I am going to have some difficulty in discussing it, but I am sure you have seen people in similar circumstances in the past four years.

Ethics in general is "right or good thinking or concept" for example "Do unto others as you would have them do unto you" is an ethical concept while morals deal with conduct, that is accepted conduct. Morals change—ethics do not!

It is true there is a short written Code of Ethics compiled by the American Medical Association, but this constitutes only a small part of medical ethics. It is not the letter of medical ethics but the spirit of medical ethics that is important. This cannot be written down. The best attempt was that written by Hippocrates.

For illustration purposes, medical ethics might be compared to the Laws of England. The common laws of England are not "laws" at all in the usual sense, but they are legal concepts that have been built up by years of precedent and judicial decision. They are the spirit of the English law; just as the unwritten part of medical ethics that have been built up by years of practice and precedent is the spirit of medical ethics. The written part of medical ethics might be compared to the written or Statutory Laws of England, that is, they are the letter of the law—the "do's" and "don'ts". It is this spirit of medical ethics that we wish to capture today.

I fully realize that doctors and scientists have very little patience and a great deal of distaste to sailing around in the "ethereal atmosphere," because we must deal with abstraction and intangible here and we are used to dealing in concrete realities. All of our education and training has been scientific, empirical and materialistic. We are all skeptics and a few of us cynics, but I am going to be foolish enough to chase this spiritual thing, because I am sure all of us have seen times when science and materialism fail. It is then that we need "spiritual straws" to grasp.

Perhaps it would help in our search for the spirit of medical ethics if we looked back into medical history and see how we obtained them.

In all early civilization medicine, magic and religion were lumped together. The witch doctor was the medicine man. This was a rich field for the unscrupulous charlatans and they out-numbered the honest practitioners. Each culture had a god of medicine. The Greek God of medicine was our own Aesculapius.

Much later in civilization, about the time of Pericles, there arose some thinking men in Greece who did not believe the wonderful cures attributed to the "gods of their fathers". It was Pythagoras, a Greek philosopher, born six centuries before Christ, who started the separation of medicine from religious superstitions and magic.

Then came Hippocrates in 160 B. C. who has rightly been named the Father of Medicine! He was an unusual physician. He is to medicine what Socrates is to philosophy. He found himself with other honest physicians classified and grouped with the witch doctors, charlatans, fakers, quacks, and ignorant practitioners of magic. None of these people were particularly respected but they made extravagant claims and promises, and the people in desperate need were afraid not to avail themselves of their services. So Hippocrates formed a school whose aim was to raise himself and his disciples out of this quagmire.

He emphasized that drugs should not be prescribed unless their benefits had been proven by observation and experiment to be of value in the specific illness. He taught that much more dependence should be put in the natural healing

*Read at First Arkansas Senior Medical Day, Little Rock, May 15, 1954.

powers of the body. He was an astute bedside observer. His description of the "Hippocratic" facies has not been improved upon to this day.

Then he laid down his code of "ethics" . . . The Hippocratic Oath. Not only did he lay it down but he and his disciples lived and practiced by it; thereby they pulled themselves out of the rank of quacks. Slowly the people began to have confidence in these physicians. This confidence has been increasing for the past 2,000 years; of course, there were people who were slow to give up and they continued to patronize the quacks who sold potions and made promises just as today there are still people who patronize the unscrupulous who hold out great claims.

By these principles Hippocrates put himself and his disciples on a pedestal. Then it was up to them to stay there. We have done very well so far and will continue to do so, so long as we hold faith with Him.

Our position has been strengthened by the dedicated lives of such men as Galen, Leonardo, Harvey, Hooks, Malpighi, Hunter, Meckle, Heister, Scarpa, Margagni, Kock, Lister, Rush Potts, Smellie, Jenner, Valsalva and many others.

How do we doctors acquire these concepts of medical ethics? There is no formal course in medical school. In fact, I'll bet half of the doctors in Arkansas have never read the complete Code of Medical Ethics. We learn it indirectly. We learn what is expected of us, and by living up to these expectations we learn our medical ethics by application. It rubs off on us from our professors and respected colleagues; we start learning the day we enter medical school and continue to do so as long as we practice medicine.

Why do we live up to these great expectations? Why do we keep our medical ethics inviolate—or some one may ask, "Do we?".

The answer is yes and no. No, we are at times lax in our relations with each other. We do have some petty jealousness and occasional back-biting; here we demonstrate that we are human. Yes, I can say we do keep the part dealing with our relations with our patients almost to a "superhuman" degree.

Have you ever stopped to think there is no honor or confidence under Heaven that compares with that given to you by a patient when he sits down in your consultation chair? Just stop to think of the position he is in. He literally lays his life and his soul in your hands for you to do with as you see fit. You have the power, quite often, of restoring to him his most valuable possession—his health. You also have the power of causing him irreparable damage by inadvertently violating his confidence. You have the opportunity to rob him; you have the power to kill him, by ignorance, mistakes, or inattention. Think what a position the patient would be in if we were less scrupulous than we are. How could anyone violate a confidence so deep as this.

On the surface it might seem incredible that a heterogeneous group of men who have nothing in common except their association, medical education, and acquired ideals, should almost universally uphold a moral concept called medical ethics, especially when they have so many profitable opportunities to violate them.

We are no more moral than similar groups of men, but we do have one of the most necessary and most useful functions in society; without impeccable integrity we would be unable to perform our function. In other words we uohold our ethics because we must. It is all we have; without it we would be nothing. We would knock ourselves off our pedestal and fall back into the mire from which Hippocrates rescued us 2,000 years ago.

Hippocrates' Oath:

I swear by Apolla the Physician, and Aesculapius and Hygeia and Panacea, and all Gods and Godesses that, according to my ability and judgment I will keep this Oath and this stipulation—to reckon him who taught me this Art, equally dear to me as my parents, to share my substances with him and to relieve his necessities as required; to look upon his off-spring in the same footing as my own brothers and to teach them this Art without fee or stipulation. And that by precept, lecture and every other mode of instruction, I will impart a knowledge of the Art to my own sons, and those of my teachers and those bound by stipulation and Oath according to the Law of Medicine but to no other. I will follow that system of regimen which according to my ability and judgment, I consider for the benefit of the patient, and abstain from whatever is deleterious and mischievous. I will give no deadly medicine to anyone if asked, nor suggest any such counsel. And in like manner I will not give to a woman a pessary to produce abortions. With purity and with holiness I will pass my life and practice my Art. I will not cut persons laboring under the stone, but will leave this to be done by men who are practitioners of this work. Into whatever houses I enter I will go into them for the benefits of the sick, and will abstain from every voluntary act of mischief and corruption and further, from the seduction of females or males.

of freed men or slaves. Whatever in my professional practice or not in connection with it, I see or hear in the life of men which ought not be spoken abroad I will not divulge, as reckoning that all such should be kept secret. While I continue to keep this Oath unviolated may it be granted me to enjoy life and the practice of the Art, respected by all men—all times; but should I trespass and violate this Oath, may the reverse be my lot.

PULMONARY EMBOLISM

JAMES F. LEWIS, M. D., F.A.C.P., Columbus, Mississippi

Pulmonary embolism occurs as a complication in a variety of conditions, injuries, and operations. It is, of course a frequently fatal complication. Each year 34,000 people die of it in the United States and 3,000,000 people now living in this country will die of this condition. One could compare the present incidence of carcinoma of the lung which is about 22,000 cases per year. No one knows the actual incidence of pulmonary embolism, and it is hard to estimate the percentage of fatal cases. Certainly all of us recognize it **much** more frequently than we did a few years ago. Many cases that were formerly labeled bronchopneumonia are now recognized as pulmonary infarction.

My own experience indicates that, while pulmonary embolism is extremely dangerous, the great majority of cases recover, particularly if early diagnosis is made and prompt measures instituted. A small percentage of cases will die within a few minutes or an hour after the embolism occurs. Yet we know that severe embolism is usually preceded by earlier, smaller emboli which should have given the signal for adequate therapy by vein ligation or anticoagulants. Of course the diagnosis of phlebitis, or coronary occlusion, or such other conditions as might lead to embolism should be made and adequate treatment given to **prevent** embolism if possible. Very often, however, embolism seems to occur without any definite prior warning.

Small emboli may go almost unheralded—showing just a little pleurisy pain perhaps—and there may be little cough, no hemoptysis, no shock, and no physical signs, or EKG or X-ray evidence. Severe pulmonary embolism, on the other hand, will produce shock, cynaosis, dyspnea, tachycardia, and great pain similar to the pain produced by coronary occlusion. A friction rub may be present after some hours or even days. EKG changes and X-ray changes may show up in a day or two. One should not examine the patient too vigorously especially regarding his taking deep breaths, as this may cause embolism.

If the patient is in distress, being in a state of shock, he should have immediately (1) oxygen, (2) atropine (1 mg. IV), (3) aminophyllin (.5 gm. IM), (4) (perhaps) pressor therapy, (such as levophed), and (5) intravenous heparin (50 mg. IV). Very commonly, however, there is no dire emergency, and the diagnosis of embolism suggests itself to the physician gradually over a period of some hours or even some days. Several times I have made the diagnosis after the patient had practically recovered—by reconsidering the possibilities and findings.

For specific prophylaxis and therapy of thrombo-embolism, we have two major methods, namely, surgical ligation of veins, and anticoagulant therapy with heparin and dicumarol. If the case is one with leg vein thrombi, ligation of the superficial or of the common femoral vein or even of the inferior vena cava can be done. Those procedures I will not undertake to discuss herein. My series of cases have been treated usually with anticoagulants without vein ligation, and more cases are treated by the medical therapy nowadays than by ligation. There are anticoagulants available in addition to heparin and dicumarol, but so far these are the usual ones used.

The field for application of anticoagulant therapy is extensive. The main indications are listed by Wright* as follows: (1) **thrombophlebitis** with or without embolic episodes, (2) **coronary thrombosis** with myocardial infarction (give dicumarol 4-6 weeks for acute coronary, but long-term anticoagulant therapy may be used in cases to prevent recurrences after one or more cardiac infarctions as well as in those with coronary atherosclerosis and acute coronary insufficiency); (3) **rheumatic heart disease** with fibrillation and multiple embolization—these cases call for long-term prophylactic anticoagulant therapy; (4) **congestive heart failure.** It is a fact that heart disease and especially failure account for a large percentage of cases of thromboembolism, hence some authors

* Wright, Irving S., **Modern Medical Monographs** (Grune & Stratton, New York, 1952). **The Pathogenesis and Treatment of Thrombosis.**

advise more or less routine prophylactic anticoagulant therapy in failure. Concerning another category of indications, namely, the postoperative state with its tendency to thrombosis, there is as yet some question whether routine prophylactic anticoagulant therapy should be used. It is used in a number of clinics, starting dicumarol the day after major surgery and continuing for a week or so. We do not use such prophylactic therapy in our clinic. However, I believe we should use it in certain selected cases because it will definitely lessen thromboembolic accidents according to various reports in the literature.

Anticoagulants serve a triple purpose. Firstly, they prevent formation of thrombus. Secondly, they limit extension and propagation of thrombus that has already formed. This is true for both the embolus and for the primary thrombus which may have formed in the leg veins, heart, or elsewhere. The infarcted area in the lung responds to the anticoagulant therapy and there is very rarely any further embolism after anticoagulant effect has been obtained. The third purpose with anticoagulants is to hasten dissolution of thrombi and the reestablishing of patency of blood vessels.

Heparin therapy is maintained by giving the aqueous solution IV or IM. Laboratory control with determination of coagulation time at intervals must be maintained. Adequate instructions are contained in the literature in each package of heparin. The IV dosage may be given by continuous drip of heparin in saline, or by intermittent injections every three or four hours. Heparinization by means of the heparin suspensions in gelatin and dextrose given subcutaneously at approximately 24 hour intervals is satisfactory in many cases, although perhaps not as good as aqueous heparin in embolism. It has the advantage of requiring very little laboratory control. Heparin may be used concurrently with dicumarol. They potentiate each other to a slight extent. Usually heparin is used early to establish immediate anticoagulant effect while dicumarol effect is being obtained. This requires 48 hours or more. After the dicumarol has sufficiently increased the prothrombin time, the heparin may be discontinued.

The correct laboratory determination of prothrombin time is essential for regulating dicumarol therapy. In starting treatment one usually gives 250 to 300 mg. the first day and 150 to 200 mg. the second day. Dosage in the ensuing weeks averages about 400 mg. per week. Individual patient response varies a good deal. I had one patient with pulmonary embolism associated with auricular fibrillation who showed full therapeutic response for 10 days following the first day's dose of 300 mg. of dicumarol. Some six months later she came in with an embolism in the popliteal artery and required about the usual dosage to maintain therapeutic level of prothrombin activity, and thereafter she was maintained on long-term dicumarol therapy until her death two years later with appendiceal abscess.

Dicumarol therapy may be continued after the patient leaves the hospital, the physician basing the dosage on the patient's previous response to the drug under strict laboratory control. A bit over 50 mg. daily is usually required to maintain adequate effect. Long-term dicumarol therapy can be maintained in certain selected cases with only weekly prothrombin determinations and the patient fully ambulatory. I have seen some cases so maintained with only one test every three weeks or so.

The dangers of hemorrhage from over-dosage of heparin and dicumarol are very slight if adequate laboratory control is maintained. If hemorrhage does occur, it can be controlled by injection of protamine if the patient is over-heparinized, plus fresh blood by transfusion; and if it is hemorrhage from excess dicumarol, one can use vitamin K (the vitamin K oxide intravenously is the best preparation), plus transfusion of fresh whole blood. In using these drugs the physician is taking a calculated risk but thrombosis and embolism constitute very major problems warranting adequate treatment. He should keep in mind three dont's: don't use the drugs if there is some condition present which would predispose the patient too much to hemorrhage; don't give too much anticoagulant; don't give too little. As to the first don't, there are various items recognized; liver disease, ulcerative lesions, blood dyscrasia with bleeding tendency, severe hypertension, and so on. Wright has recently pointed out also that alcoholism and malnutrition temporarily increase the sensitivity to coumarin drugs until food intake is taken.

Most cases of pulmonary embolism are kept in bed 10 to 16 days; some, sicker, are bedfast longer. Penicillin and other antibiotics are used in an effort to prevent infection in the area and are indeed most helpful. Other general measures are used as indicated in the individual cases.

I would like to present some cases representing embolism arising in various conditions—postoperative, cardiac failure or fibrillation, and thrombophlebitis. Most but not all of these cases received the benefit of anticoagulant therapy. Some were most certainly cases of pulmonary embolism, in

others the diagnosis was more tentative. I will introduce the cases by showing the chest X-rays but I do not want to create the impression that the X-ray is the all-important diagnostic feature. Clinical judgment is the all-important thing. If infarcts do show up, they are not often of the classical triangular shape on the film. Very commonly small infarcts do not show up on X-ray.

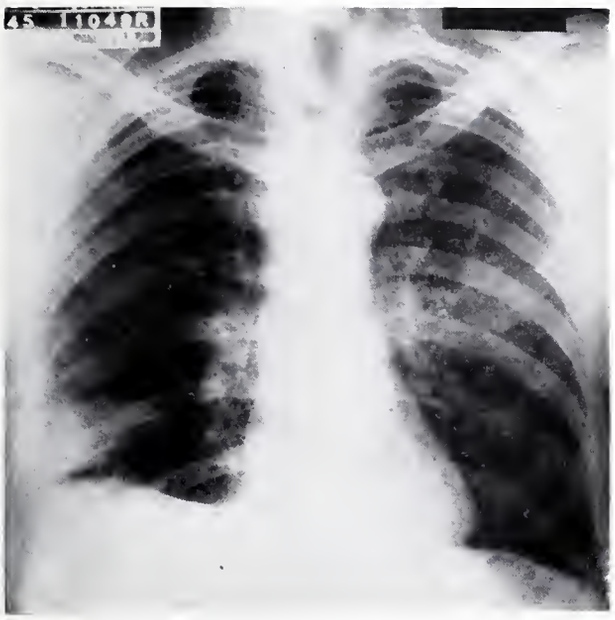


Figure 1

S.S.H. (W. M. 51) Wedge shaped shadow typical of infarct. Two weeks after onset of chest pain. Had hemoptysis and friction rub. No recognizable thrombosis elsewhere.

Figure 3

Mrs. W.M.K. (W. F. 61) Six days after onset pleural pain and three days after starting penicillin therapy. Rounded area increased density right lower. (Breasts held up.)

Figure 2

Same. Two months after onset—slow clearing—antibiotics given but no anticoagulants. (We would definitely use anticoagulants now, even with much less evidence of embolism.)

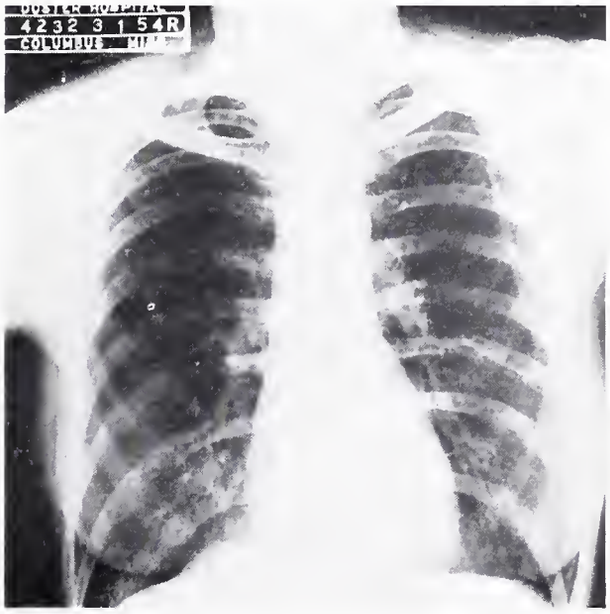


Figure 4

Same one week later. (Dicumarol used.)

minimal

side

effects

ACHE

LEDERLE LABORATORIES DIVISION AMERICAN Cyanamid co

One of the notable qualities of ACHROMYCIN, the Lederle brand of Tetracycline, is its advantage of minimal side effects. Furthermore, this true broad-spectrum antibiotic is well-tolerated by all age groups.

In each of its various dosage forms, ACHROMYCIN provides more rapid diffusion for prompt control of infection. In solution, it is more soluble and more stable than certain other antibiotics.

ACHROMYCIN has proved effective against a wide variety of infections caused by gram-positive and gram-negative bacteria, rickettsia, and certain virus-like and protozoan organisms.

ACHROMYCIN ranks with the truly great thera peutic agents.

OMYCIN*

HYDROCHLORIDE
Tetracycline HCl Lederle

River, New York

Lederle

*REG. U.S. PAT. OFF.

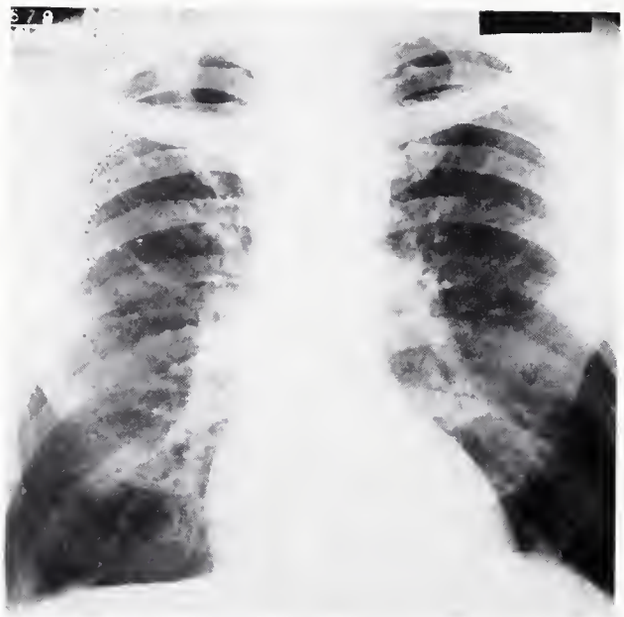


Figure 5

A.C.G. (W. M. 54) Case of hypertensive heart disease had decompensation three weeks before this picture which shows an abscess cavity which had formed within that period of three weeks. (Did not show cavity three weeks before.) In retrospect diagnosis of embolism was made.

Figure 7

Mrs. D.M. (W. F. 52) Typical history and signs of pulmonary embolism occurring three weeks after onset of thrombophlebitis in leg veins. Anticoagulants given. Positive sputum (tbc) ! ? ! on two occasions through many negative smears and cultures.

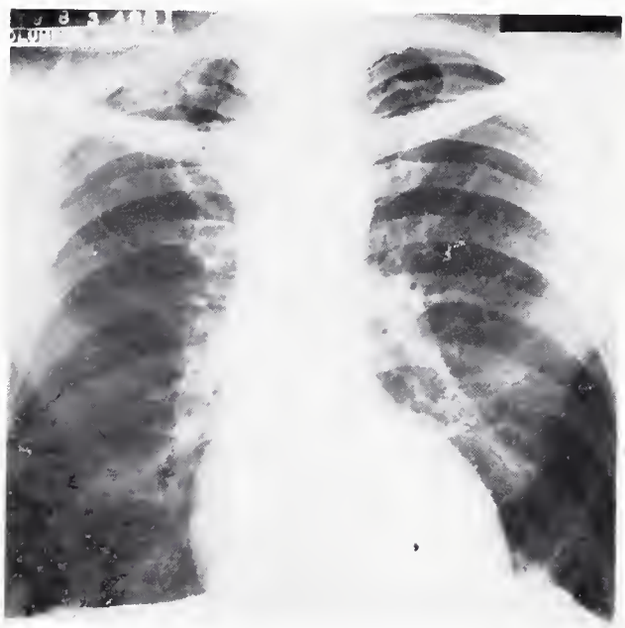


Figure 6

Same. Apex nearly clear. Antibiotics only. Not tbc.

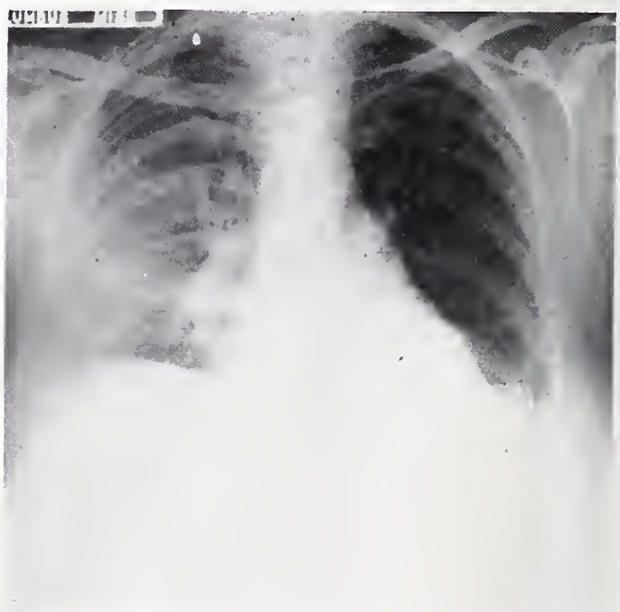


Figure 8

Same one week after first film. ? Abscess. Tough differential diagnosis. Sudden death two months later with heart block.

Probable sequence was heart disease, thrombophlebitis, and embolism, with tbc incidentally becoming manifest. Can't imagine mistake in laboratory!

Figure 9

Fig. 9—W.J.H. (W. M. 50) Hernorraphy ten days before onset pleural pain, cough, hemoptysis. Anticoagulant therapy. Something in right lower lung field. Prompt recovery.

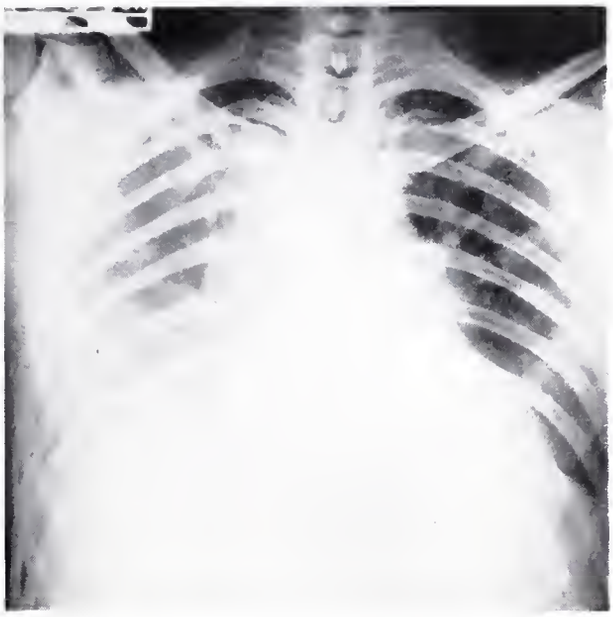


Figure 11

Same. Two days later extensive pulmonary involvement is shown.

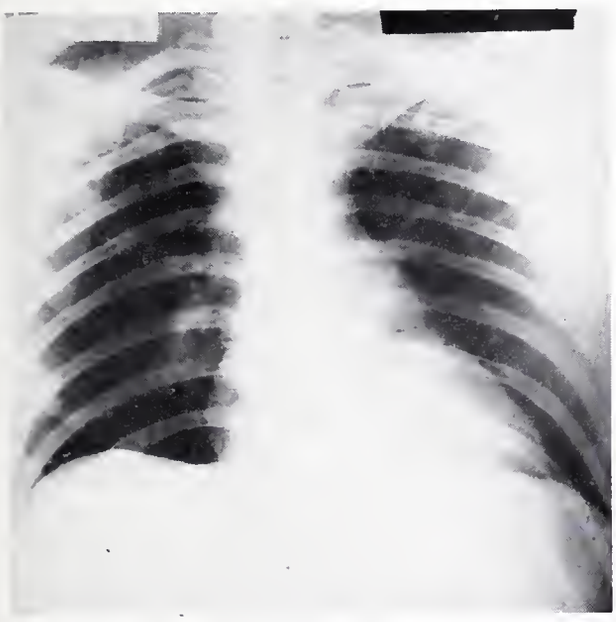


Figure 10

R.G. (W. M. 25) Open operation on patellar fracture ten days before sudden collapse with very severe chest pain. Anticoagulants, etc., started promptly. This bedside film made 12 hours after onset shows little or nothing, yet patient had pleural pain, friction rub, hemoptysis, and typical EKG signs of embolism all showing up within two days.

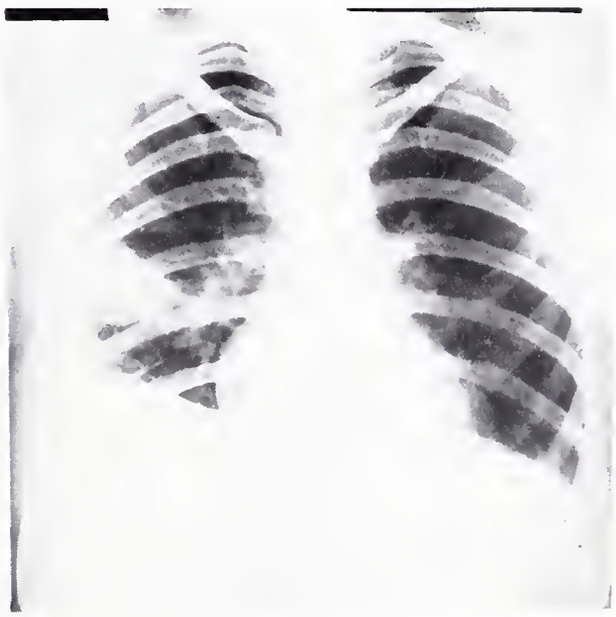


Figure 12

Fig. 12.—Same. One month later patient doing all right but abscess has formed. Right diaphragm is high.

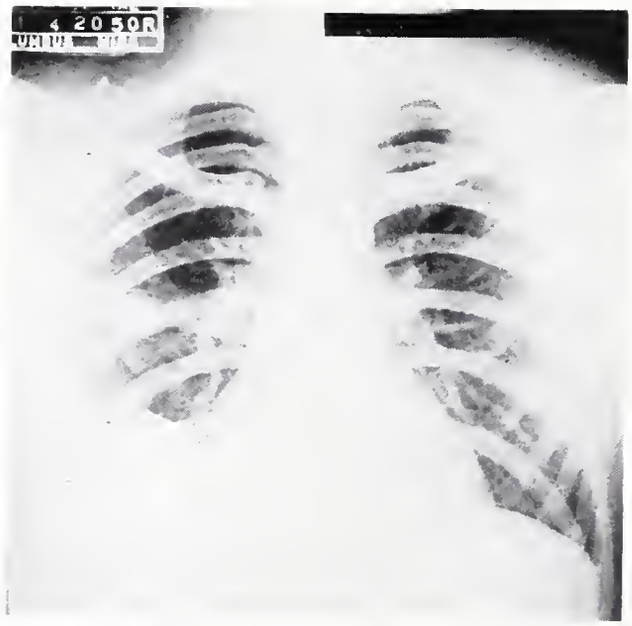


Figure 13

Fig. 13—Same. Abscess healed after another month.

Figure 14

Mrs. I.T.A. (W. F. 60) This case was mentioned in the text above as having recurring embolization from auricular fibrillation. This film represented, we felt, a pulmonary infarction and there had been a previous similar episode. Nine months after this there was a popliteal embolism and following this she was maintained on dicumarol until her death two years later with an appendeal abscess. (We didn't see her in this final illness until appendix had already ruptured.)

These cases have been presented simply as interesting cases encountered in the course of a private practice. No attempt is made to evaluate anticoagulant therapy in these few cases. They do, however, bring out some of the diagnostic and therapeutic considerations involved in pulmonary embolism. Anticoagulant therapy is here to stay, like the automobile, and it isn't necessary now to prove its efficacy. It should, I believe, be in more general use. Perhaps the chief deterrent is the laboratory control necessary, and indeed accurate laboratory control IS essential. There may be time when such therapy may be used needlessly and mistakenly, like any other treatment, but by and large there will be more sins from omission of anticoagulant therapy than there will be of commission.

NATIONAL NURSE WEEK

On August 24th, President Eisenhower signed a joint resolution of Congress setting forth the week of October 11-16 as National Nurse Week. The purposes of this resolution were to encourage public recognition of the roll of nursing in the nation's health, welfare and defense; and to focus attention on the nurses' needs and on nurses' recruitment and education.

Representatives of twelve national organizations and agencies met in Washington on August 25th and set up a plan for implementing the program adopted by Congress. Included were: American Nurses Association; National League for Nursing and Committee on Careers in Nursing; American Hospital Association; American Medical Association; American National Red Cross; American Public Health Association; Catholic Hospital Association; Protestant Hospital Association; National Student Nurse Association; United States Department of Defense; United States Department of Health, Education, and Welfare; and the Veterans Administration.

Dr. Hoyt Choate, Chairman of the Arkansas Medical Society Committee on Liaison with the Nursing Profession, reports that a concerted effort will be made to bring National Nurse's Week to the attention of the public through the cooperation of the interested agencies at a local level. He urges that county medical societies and individual members contact members of the nurses organizations in their community and cooperate in planning and obtaining publicity through radio and television programs and newspaper articles.

COMING EVENTS

CLINCIAL CONGRESS OF THE AMERICAN COLLEGE OF SURGEONS
Atlantic City—November 15 to 19, 1954

OKLAHOMA CLINICAL SOCIETY
Oklahoma City, Oklahoma—October 25-28 at Biltmore Hotel

ARKANSAS MEDICAL SOCIETY
Hot Springs—May 30 - June 1, 1955

SOUTHERN MEDICAL ASSOCIATION
St. Louis—November 8-11, 1954

SOUTHWESTERN SURGICAL CONGRESS
Oklahoma City—September 20-22, 1954

★ Editorial ★

ORCHIDS TO HOT SPRINGS

It frequently happens that much good work is accomplished by builders of a community or of a state which receives little publicity and no praise, and sometimes it deserves both. The thought in mind is the work that is being done in Hot Springs.

For the past six months, civic leaders, business men and physicians of the Arkansas Spa, have been quietly working on the foundation of a Physical Medicine Center on the site of the government bath house there. Although the details of its organization are not yet completed the JOURNAL feels some comment is appropriate.

There is no reason why such an institution could not be supported and maintained not only by Hot Springs and Garland county but also by Arkansas and contiguous areas. The value of thermal baths is unquestioned in Warm Springs, Ga., in the treatment of polio. Without knowing their plans, the JOURNAL dares to suggest that some institution similar to the one at the Georgia Spa could be created, and operated in Hot Springs.

The treatment of Chronic Poliomyelitis for this entire area could be put on a sound basis. Arkansas cannot maintain and support more than one center for the treatment of Chronic Polio, attempts have been made in Fort Smith and other cities but have been abandoned because they were economically unsound. If Hot Springs embarks on such a program we'd like to see every town in Arkansas offer support for the proposition.

THANKS MR. LLOYD HENRY

We counted stories in two of our contemporary newspapers for a short period not long ago, and came up with an astonishing observation. A large percentage of newspaper space is devoted to two sets of folks—those who do not do their civic and personal duties, and who get news-notice by dereliction, and those positive derelicts who do something, but which is the wrong thing! Those classes made up more than 60% of the stories about people.

Apropos of that cynical observation, it is a pleasant relief to come upon a story about someone who does his duty, does it well, and who does it without fanfare and/or publicity. We came upon one in the story of an attorney, a public prosecutor, who saw an illegal act, took steps to stop it and to punish the offender.

We speak of Mr. Lloyd Henry of Augusta, Prosecuting Attorney of that district who investigated the case of one John R. Stark who moved to Pangburn and it was reported that he claimed to be a retired Army physician and opened an office. Mr. Henry investigated the case on the notification of the State Medical Board, and Stark was brought to court and fined and sentenced. He posted bond and left the state. Mr. Henry located him in Missouri, and had him returned on a new charge and he was given a prison sentence.

The Journal salutes Mr. Henry as a competent and conscientious public official. Arkansas does well to have in office, men of his stamp and caliber.

LIFE EXPECTANCY JUMPS

Average length of life in the United States has reached a record high of 68 and one-half years, a gain of nearly four years in the past decade, according to vital statistics compiled by the U. S. Public Health Service.

Women on the average outline men by six years. The average lifetime expected for women at birth is 71.8 years, while the average for men is 65.9 years. This difference in the life expectancies of men and women has increased sharply since 1900 when females outlived males by an average of only two years.

The JOURNAL and Arkansas physicians salute the Georgia Medical Society on its 150th Anniversary in October, 1954.

Foreign Operations Administration has set aside nearly half a million dollars to give 100 European physicians a trip to the United States, presumably to study in our schools and hospitals. This gift is being sponsored by the American College of Surgeons.

To many members of the College of Surgeons, this will come as a shock. Many of them have given time and money to try to get our government to let medicine alone and to pare down the giveaway programs.

A Supplementary "Grant" of five million was voted from general revenues in the last days of the 83rd Congress to "administer the broadened 'social security' program." **And we thought all the time that "S. S." was more than paying its way!**

Each summer is the approximate time of grants of funds from individuals, trusts, foundations, etc., to the various medical schools. In the recent JOURNAL (September, 1954) announcement was

made of the annual grant from the American Medical Educational Fund to the University of Arkansas Medical School of $15,000 plus.

This sum comes from the AMA sponsored AMEF, to which the AMA itself has put in more than two million. Arkansas physicians have contributed to some extent but more could be done. A few states have added $10.00 to their annual dues which is separated and put in the AMEF. Our membership can well afford to be generous in this field. It means many times our contribution is coming back to our medical school every year.

Private sources have also been of considerable help. Winthrop Rockefeller has added funds to augment some salaries in the school, $11,000 being granted in July. The Atomic Energy Commission and the National Institute of Health have made $53,500 and $25,000 grants to the school for work which will begin in October and a part of which will take five years to complete.

We doubt the wisdom of taking taxes from individuals then applying (after the government "take") the funds to public grants can be ethically defended. It amounts to "forced donations," to which, a public, if they thought through the matter, would object.

The other alternative, of course, is to support such institutions by gifts. It will pay us to be liberal. An oft quoted phrase, "I hold every man a debtor to his profession," well illustrates our point.

NUMBER OF PHYSICIANS IN U. S. REACHES NEW HIGH

A record graduation of 6,861 physicians during the past year by our nation's medical schools has boosted the ratio to an all-time high of one physician for every 730 persons in the United States.

Every physician in America ought to know that they owe a debt of gratitude to two physicians who appeared before Senate Committees on July 6, 1954. Their testimony has appeared in the Journal of the American Medical Association and they supported the cause which would leave physicians free to practice medicine and buy their own life and health insurance as a free people should. They opposed regimentation and government by "unelected" bureaucrats and inclusion into the "Social Security" system. It will be well to thumb through your July AMA Journal and read these strong reports. They read like the reports of strong men standing up for political and economic freedom which is threatened and which is being impaired in these United States.

F. J. L. Blasingame of Wharton, Texas, and James L. Doenges from Anderson, Indiana, turned in magnificent jobs. This Journal congratulates them.

Arkansas TRAVELING

And Clipping Bits Here and There

Moreover, as Mr. John S. Cooper points out in the Wall Street Journal, "The variety of protection today is almost endless. . . . Policies are available for everything from dental cavities to 'catastrophic illness' with surgical bills as high as $10,000." This seems due in large measure to increased competition for the business. About 800 insurance companies are now active in the field, in addition to the Blue Cross and Blue Shield plans. And some labor unions and corporations have plans of their own.

This is certainly proof that the vast majority of Americans can and will take care of their health needs on a voluntary basis. The minority which is unable to do that can be helped without subjecting all the rest of us to compulsory health insurance, which almost inevitably would be the prelude to some form of socialized or state-dominated medicine.

—Editorial, Southern Standard, Arkadelphia.

Dr. Paul F. Whitaker, Committee on Grievances of the Medical Society of North Carolina—"It seems to your Committee on Grievances that it is imperative that we perfect our tools in human relationships to the same point that we have perfected the tools of science, in order that we may enter into the minds of our patients with sympathy and understanding, without judgment or criticism, and in a spirit of true helpfulness."

"I believe that I can say that most dissatisfaction arises from the fact that the doctor and the patient fail to discuss in advance the question of fee . . . It is embarrassing to receive a complaint from some patient saying that a doctor is suing him for a fee he is unable to pay, and have the patient ask why does your profession say that no person needs go without medical care whether or not he has the money?"—Morris Nielsen, Chairman, Council on Professional Ethics, Nebraska State Medical Association.

Herbert Hoover, in his West Branch, Ia., speech on his 80th birthday—"One of the post-war cousins of socialism is the so-called 'welfare state'. This poison gas is generated by fuzzy-minded intellectuals. Its slogan is 'planned economy.' The phrase itself was borrowed from totalitarian governments. The end of it would at least be a government wherein whatever is not forbidden would be compulsory."

Lewis J. Moorman, M. D., will be long remembered by his colleagues and former students, as well as all who have read "Pioneer Doctor"—the account of his own early experiences. His death on August 2, 1954, terminates 15 years of service as the Editor-in-Chief of the JOURNAL of the Oklahoma State Medical Association. He had a wide influence in medical circles for many years.

Clarence T. Shoch, President, National Society of Professional Engineers — "The self-employed professional engineers are victims of an 11th-hour decision by House-Senate conferees on the Social Security expansion bill. To force self-employed professional engineers into the Social Security system is an arbitrary and discriminatory splitting of the professional groups, supported neither by logic nor justice. This last-minute action is not a victory for one group of professionals over others because the floodgates have now been opened."

California Gives $100,000 to AMEF

A $100,000 gift from the California Medical Association was received last week by the American Medical Education Foundation. Mr. John Hunton, executive secretary of the association, said that the donation represents a treasury grant of the CMA and brings California's total income for 1954 to $117,230, including contributions to AMEF from 255 individual California physicians.

Arizona Dues Increase Nets $7,230

Another outstanding contribution recently received by the Foundation was a check in the amount of $7,230 from the Arizona Medical Association, representing a $10 per member dues increase voted for AMEF by the association. Arizona and Utah have accepted the Illinois plan as a method of collecting contributions from their state medical society memberships. Using the plan for the second year, Illinois still leads the nation in total income of $163,120.

First Legacy From Detroit Physician

The Foundation was notified recently that the late Andrew B. McGraw, M. D., of Detroit, Mich., had bequeathed $5,000 to AMEF in his will, which will be probated at Detroit on September 13. This was the first such legacy awarded AMEF since its inception in 1951.

W.M.A. NEEDS IMMEDIATE FINANCIAL SUPPORT. Doctors who are members of the United States Committee of the World Medical Association now are receiving letters, citing the present financial plight of the W.M.A. and urging immediate financial support to build up a depleted treasury.

In an urgent appeal from Dr. Louis H. Bauer, secretary-treasurer of the U. S. Committee, members are being asked to talk about the W.M.A. to their friends and sign them up. The membership fee is only $10.

"At the moment," Dr. Bauer said in a note to me, "we do not have sufficient funds either to handle the General Assembly or run the association for another year."

Since its founding in 1947, the W.M.A. has earned increased respect from international governmental organizations.

"But," Dr. Bauer says, "there is a constantly growing tendency for decisions affecting all of medicine to be made at the international level. This tendency is a threat not only to the future of medicine itself, but to the rights and privileges of every practicing physician. One example is the current attempt of incompetent organizations to draft a Code of International Medical Law which would affect all physicians in peace as well as in war. The World Medical Association is the only international organization which can and does speak from the non-governmental standpoint and from the standpoint of free enterprise. However, it can only continue to defend your interests if it has adequate financial support."

Consequently, he is asking doctors all over the country to join in a renewed membership campaign. Application blanks can be secured from Dr. Louis H. Bauer, World Medical Association, 345 East 46th Street, New York 17, N. Y.

"It's unwise to pay too much, but it's worse to pay too little. When you pay too much you lose a little money, that is all. When you pay too little you sometimes lose everything because the thing you bought was incapable of doing the thing it was bought to do. The common law of business balance prohibits paying a little and getting a lot. It can't be done. If you deal with the lowest bidder it is well to add some for the risk you run."

—John Ruskin.

"By doing something differently, we do not necessarily do it any better."—Hardy Kemp, Journal Southern Medical Association, May, 1954.

You've probably forgotten it, but the Executive Secretary of the Arkansas Medical Society maintains a Placement Bureau for Physicians. County Medical Societies usually hear of an area first and where a community needs and can support a physician, application should be to Mr. Schaeffer at his Fort Smith office.

"TODAY'S HEALTH" will be put in 100 public and school libraries on the action of the Council of the Arkansas Medical Society on August 29. Some County Societies already provide this service for local libraries, and the Council hopes by its action to make the publication available to every library in the state.

OBITUARY

SAMUEL SHAVER BEATY, 77, died in a Little Rock hospital August 4.

Dr. Beaty was born on August 12, 1877, and had been practicing medicine in England since April 15, 1903. Last year he was honored with a celebration in recognition of his 50 years' service there.

He was a member of the Arkansas State Medical Society and a member of the American Medical Association. He had served as president of the Lonoke County Medical Society and had done part-time work with the State Health Department.

Dr. Beaty had been a member of the Board of Stewards of the England Methodist Church for the past 40 years. He was a 32nd degree Mason and a member of the Shrine.

Survivors include his widow; one daughter, and three grandchildren.

Funeral service were conducted at the Methodist Church and burial was at Mulberry Cemetery.

SMITH WALKER DOUGLAS, SR., 84, died in his home in Eudora, August 12.

Dr. Douglas was forced into retirement by failing eyesight about 10 years ago. He was an officer of the Arkansas Medical Society at the time. He was a past president of the Southeast Arkansas Medical Society, past president of the Chicot County School Board, and honorary member of the Masonic Lodge. In 1948 he was honored at a "Dr. Douglas Day" celebration there.

A native of Mississippi, he moved to Eudora and began the practice of medicine there in 1910.

A veteran of the Spanish-American War, Dr. Douglas was the only honorary member of the local American Legion Post.

He is survived by his widow, Mrs. Anna Douglas, five sons, four daughters, a brother, and four sisters.

Funeral services were conducted in the Eudora Baptist Church. Burial was in Grapevine Cemetery.

ALLEN ENNIS COX, physician and surgeon at Helena the past 50 years, died August 16 in a Helena hospital at the age of 82.

He was born in Honea Path, S. C., May 11, 1872. He graduated at Vanderbilt University in 1894. In 1904 he moved to Helena, where he has been actively engaged as a physician and surgeon for the last half century.

Dr. Cox was a Baptist, a member of the Phillips County Medical Society and of the Mid-South Medical Society, of which latter organization he was a past president. He was a member of the American Medical Society for over 50 years. For the past 30 years he was a member of the St. Francis Levee District at West Memphis, as a representative of Phillips County.

He is survived by one son. Burial was in Oakwood Cemetery at Brownsville, Tennessee.

JOHN FORREST McKNIGHT, 92, pioneer physician of Southwest Arkansas, died in a Shreveport hospital after a long illness, on August 21.

Dr. McKnight began the practice of medicine at Walnut Hill in Lafayette County and remained in the same community until his retirement in 1940 at the close of 54 years of service.

He was born in Auburn, Tennessee, Sept. 5, 1862, and came to Arkansas at the age of 21. He attended Vanderbilt University in 1885 and received his M. D. degree from Tulane University in 1892.

He was a charter member of the Lafayette County Medical Society and was made an honorary life member of the Arkansas Medical Society in 1937.

He was active in all civic and religious activities of the community, serving as local school board director and member of the county board of education.

He was a member of the Baptist Church, the Masonic Lodge, from which he received a 50-year pin in 1940, and a charter member of Walnut Hill Chapter of the Eastern Star.

His wife, the former Laura Ann Miers, died a few months ago. They had celebrated their sixtieth wedding anniversary in February, 1954.

Funeral services were held at the Bradley Baptist Church. Graveside services were at the Walnut Hill Cemetery in charge of the Masonic Order.

THOMAS SOUTER, 78, of McNeil, died August 28 in a Texarkana hospital. Dr. Souter was a native of Columbia County. He has been a practicing physician for 50 years. Survivors include his widow, a daughter, and two brothers. He was active in the Arkansas Medical Society, and in the Columbia County Medical Society.

Burial was in City Cemetery, in McNeil.

TUBERCULOSIS ABSTRACTS

A Review for Physicians

ISSUED MONTHLY BY THE NATIONAL TUBERCULOSIS ASSOCIATION

THE STAGE IS SET—

A Program for More Effective Control of Tuberculosis in the United States

JAMES E. PERKINS, M. D., National Tuberculosis Association, April, 1954

The year 1954 marks the fiftieth anniversary of the National Tuberculosis Association, the anniversary of the nationwide fight against tuberculosis in the United States. The campaign against tuberculosis as conceived by the founders of the National Tuberculosis Association is nationwide in scope but the basic unit is the local, self-governing tuberculosis association. The local associations work together in democratically constructed state associations. The National Association serves the state and local associations, coordinates their efforts, and carries on those responsibilities which can be handled only by a national body.

As the leader of the volunteer forces in the war against TB, the National Tuberculosis Association coordinates the efforts of more than 3,000 voluntary tuberculosis associations and aids them to reexamine, strengthen, and expand their programs for better service in accordance with local needs; works with its affiliated associations and supplies them with the health education materials needed to spread knowledge about the tuberculosis problem; advances scientific knowledge about tuberculosis, through its medical section, the American Trudeau Society; works for the improvement of rehabilitation services for patients; promotes efforts to find cases of tuberculosis; stimulates the maintenance of adequate official health, welfare, and educational agencies; promotes the recruitment and training of skilled professional personnel for tuberculosis control; cooperates with all the forces fighting tuberculosis; and seeks to improve international efforts to control tuberculosis.

The activities of the voluntary tuberculosis association in communities throughout the United States are financed by the annual sale of Christmas Seals. Of the total proceeds, 94 per cent is used by the associations within the states where the money is raised. Six per cent is allotted to the National Tuberculosis Association.

When the NTA was founded in 1904, TB was the major health problem, the first cause of death in this country. Tuberculosis is now the sixth cause of death (1950). This decline represents great progress, but even a brief summary of the present situation indicates the seriousness of the problem today.

Tuberculosis is a totally unnecessary disease. It can be prevented. It can be cured. Yet, tuberculosis remains a leading cause of death in the age group from 15 to 34—decisive years in the lives of young people. Tuberculosis is one of the greatest killers among the American Indians and among Americans of Spanish descent. The death rate among Negroes is three and a half times the rate among whites. Tuberculosis kills approximately twice as many men as women. TB mortality is high among people who receive public assistance and inmates of mental and other institutions.

But the TB problem is not as adequately stated in terms of death as it is of living people—the 400,000 people who have active TB today. They may not die of tuberculosis, but they will have to live with the disease and with the inevitable changes it brings. Within the next year, about

100,000 people will catch TB. We are not preventing the **spread** of tuberculosis.

What does "a case of tuberculosis" mean? It means a suffering human being with a chronic, debilitating disease; a person who may have to undergo a long period of hospitalization; young people whose hopes may be blasted.

Tuberculosis must be considered not only in terms of its cost in lives and in human suffering. Its cost in money is important to the economic life of the country. The total TB bill in the United States is conservatively estimated at more than **600 million dollars** a year! This figure includes the cost of case finding, care of patients, public health nursing, health education, rehabilitation, medical research, pensions to veterans, and public assistance to patients' families.

Most of this comes out of the taxpayer's pocket. The rest is borne by private agencies, individuals, and their families. The cost of one case of tuberculosis is difficult to determine. However, a rough estimate is $15,000, including medical care, compensation, pensions, relief payments and loss of wages.

Tuberculosis is caused by a germ, the tubercle bacillus, which is spread usually through the air by persons with active disease. Many adults have at some time come in contact with the tubercle bacilli, but the disease has made headway in only a fraction. Approximately 800,000 persons are believed to have inactive tuberculosis. The disease has been arrested, either spontaneously or by medical treatment. Although the disease may remain in this arrested state, these people must have regular medical supervision. Together with the estimated 400,000 active cases, they constitute a group of 1,200,000 people who need medical supervision. Of the 400,000 active cases, about 250,000 are known to health authorities. The other 150,000 are the "unknown" cases—the people whose disease has never been reported.

According to a 1953 survey, 130,000 hospital beds are set aside for tuberculosis patients in the U. S., including 22,000 in mental and penal institutions. If all the unknown cases of TB were found and all patients who refuse hospitalization were to accept it, they would be unable at the present time to get hospital treatment. Yet, modern medical opinion stresses the importance of hospital treatment of the tuberculous.

There is no simple solution to the problems of tuberculosis control. The mere spending of more money will not solve them. We need to improve further our over-all program of tuberculosis control in which official and voluntary agencies join in a concentrated, cooperative effort.

Such a program includes:

Greater efforts to find all cases of tuberculosis. Case finding among high-prevalence groups—such as admissions to general hospitals, certain racial and national groups, mental patients—must receive priority and be intensified.

Greater efforts to make the best techniques of modern TB treatment readily available to all patients. This means provision of adequate hospital beds and supervision when hospitalization is impossible. It means improved education of the medical, nursing, and ancillary professions. It means better education of patients. It means medical research for further knowledge about tuberculosis. It means rehabilitation.

Greater efforts to build up the resistance of people to tuberculosis infection. Specific resistance calls for medical research to find a superior vaccine and wider use of our best present vaccine, BCG, in the groups most vulnerable to tuberculosis infection. Improved nonspecific resistance calls for more education of the general public in nutrition and other aspects of healthy living.

This, then, is the program for tuberculosis control in this country. **It is difficult—it is ambitious. It is necessary.** Every case of tuberculosis is an indictment against society—irrefutable evidence that someone, somewhere was either ignorant or callous to his responsibility in preventing unnecessary human suffering.

The stage is set for total victory. There must be no faltering at this critical point!

The office equipment of the late Dr. J. J. Baker of Magnolia, Arkansas, is for sale. Good office location also. Contact—

MISS CLYDE BAKER
414 N. Washington Street
Phone 65
Magnolia, Arkansas

PERSONALS AND NEWS ITEMS

Earl Parsons, Little Rock, addressed the Mid-Continent Psychiatric Association Meeting in Little Rock on September 19, 1954, on "Problems of Group Therapy in Private Practice (Particularly Failures)".

"Acute Abdominal Emergencies" by S. W. Hawkins of Fort Smith was published in the September Journal of the Louisiana State Medical Society.

Harry E. Murry, Texarkana, with Mrs. Murry, missed a lot of our summer heat by touring Canada in August.

Ben H. Pride, Fort Smith, took a vacation trip to Cuba in August.

Ralph Kramer has returned from a two-year stint in the Navy and re-opened office with John Ben Stewart in Fort Smith.

Paul H. Woods, Hot Springs, is doing resident training in Ob. and Gymn. in San Francisco. He is at St. Francis Memorial Hospital.

F. J. Scully addressed the Kiwanis Club of Hot Springs in August on one of his hobbies, History of Medicine in Garland County.

David Dawson has moved from Newport to Batesville and will be associated with Dr. Gray's Hospital.

Robert E. Lee Saxon, Little Rock, was honored recently with the "Golden T" of the University of Tennessee. He received his medical degree in Nashville in 1904.

President-Elect L. H. McDaniel, Tyronza, has donated a considerable amount of quinine, which he found in an old inventory, to a Presbyterian Mission in Lahore, Pakistan.

Past-President R. C. Dickinson was awarded a degree at the International College of Surgeons meeting in Chicago in September.

J. J. Monfort spent a two week vacation attending the Anglican Congress at Minneapolis.

William W. Christeson opened his offices in the Donaghey Building in Little Rock for the practice of urology on September 1.

Jere L. Long, Secretary of the Monroe County Medical Society, reports two new members, Terry J. Swaim and F. M. Wilson who are associated in Cotton Plant.

S. A. Drennen announces that he will close the City Hospital that he and Mrs. Drennen have operated in Stuttgart for 26 years. The date set for the closing is October 1, and he will continue practice in a suite of offices.

John S. Griffin has become a member of the Society through the Miller County Medical Society. Griffin is associated with the Collom and Carney Clinic in Texarkana.

The Drew County Medical Society publishes a health column in the Advance-Monticellonian each week, under its own by-line. It is called, "You and Your Doctor." The JOURNAL believes this is one of the finest ways to polish up our Public Relations. Orchids to Drew County doctors.

Richard C. Petty and James W. Freeland, both of Star City, recently became members of the Arkansas Medical Society through the Lincoln County Medical Society.

W. T. Holman, Fort Smith, has just returned from a vacation in Washington, D. C., Virginia, and North Carolina. While in Washington he was the guest of Congressman Trimble and visited both the House and Senate. On the way home he spent several days as the guest of former Governor William M. Tuck (now Congressman) at his summer home near South Boston, Va.

S. M. Graves, Clarksville's oldest practitioner, spent two weeks vacation in Hot Springs, during August.

Max Roy, Forrest City, was a patient in a Rochester, Minnesota, clinic during August and September.

Louis K. Hundley, Pine Bluff, will address the State Public Health Association in Little Rock on October 28.

A number of Arkansas physicians' names appeared on the program of the 6th Annual Southwestern Surgical Congress, in Oklahoma City, September 19-22. Headed by Fred H. Krock, Fort Smith, who is Vice President of the Congress,

other members of the Arkansas Medical Society who participated in the program, panels, etc., are: Ellery Gay, Little Rock; Louis P. Good, Texarkana; Louis O. Lambiotte, Fort Smith; W. G. Cooper, Jr., Little Rock; Eugene T. Ellison, Texarkana.

PROCEEDINGS OF SOCIETIES

The Oklahoma City Clinical Society will open it's twenty-fourth annual four-day conference on October 25, 1954.

An outstanding program of postgraduate teaching has been arranged. This includes lectures and discussions by sixteen distinguished guest speakers selected from various medical and teaching centers throughout the nation, as well as many Oklahoma City teachers and physicians. Dr. Walter B. Martin of Norfolk, Virginia, president of the American Medical Association, will give an address at the first banquet meeting October 25th. The entertainment will include dinner meetings, the annual Clinic Dinner Dance and the Stag Smoker.

A cordial invitation is extended to all physicians who are members of their County Societies to attend this meeting, October 25-28.

The Craighead-Poinsett County Medical Society had a dinner meeting on September 2nd in Jonesboro. Mr. James L. Garthright, Professor of Medical Jurisprudence, University of Tennessee College of Medicine, Memphis, spoke on, "The Doctors Duties and Responsibilities in Court." A round table discussion followed the talk.

Two new forms are proposed by Arkansas Obstetrical and Gynecological Society for the adoption of children through the State Welfare Department. They follow:

Dr. .....

Please complete the following form giving the Arkansas Child Welfare Division information concerning our physical and mental qualifications in regard to the adoption of a child.

Husband .....

Wife .....

This medical form has been recommended and approved by the Arkansas Obstetrical and Gynecological Society. It will be reviewed by a board of three practicing physicians from the Arkansas Medical Society.

Please mail this form to the committee chairman, Dr. B. James Reaves, Donaghey Bldg., Little Rock, Ark.

Medical Form for Prospective Parents Seeking Adoption of a Child Through the Child Welfare Division, State of Arkansas, Department of Public Welfare.

Name and address .....

Medical examination of prospective mother: .....

Medical examination of prospective father: .....

Medical report on other members of the family if pertinent: .....

FERTILITY AND STERILITY EXAMINATION:

Pelvic examination (wife) .....

Genital examination (husband) .....

Huhner test: .....

Semen analysis (if indicated): .....

Total count .....

Percentage and duration of motility .....

Percentage of abnormal forms .....

Signs of ovulation: Method .....

Results .....

Tubal patency: Method .....

Results .....

History of previous pregnancies: .....

Summary of examining physicians opinions regarding this couple as to their home, their capacity as foster parents and their prospects for having children of their own .....

Signed ..... M.D.

J. F. Kelsey, Secretary,
Ark. Ob. & Gyn. Soc.

The Ouachita County Medical Society met at the Duck Inn in Camden, September 2. James Wortham, Professor of Medicine, University of Arkansas School of Medicine gave a talk on "What's New in Medicine" and Willis Brown, Professor of Obstetrics and Gynecology, University of Arkansas School of Medicine, spoke on "What's New in Ob and Gyn."

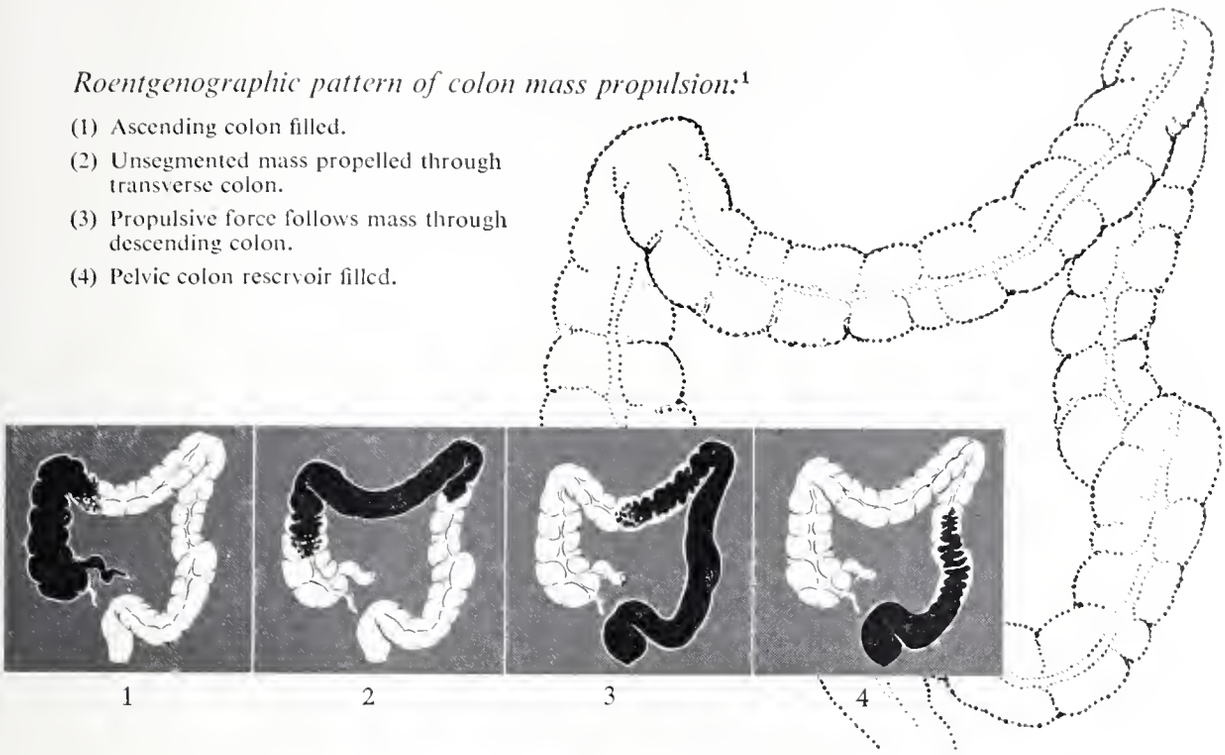
Roentgenographic pattern of colon mass propulsion:[1]

(1) Ascending colon filled.

(2) Unsegmented mass propelled through transverse colon.

(3) Propulsive force follows mass through descending colon.

(4) Pelvic colon reservoir filled.



Reestablishing Bowel Reflexes with Metamucil®

Nervous fatigue, tension, injudicious diet, failure to establish regularity, too little exercise, excessive use of cathartics—all factors which contribute to constipation.[2]

Sufficient bulk and sufficient fluid form the basic rationale of treatment of constipation with Metamucil.

Metamucil (the mucilloid of Plantago ovata) produces a bland, smooth bulk when mixed with the intestinal contents. This bulk, through its mass alone, stimulates the peristaltic reflex and thus initiates the desire to evacuate, even in patients in whom postoperative hesitancy exists.

Factors Contributing to Chronic Constipation

Such gentle stimulation is of distinct advantage in reeducating and reestablishing those reflexes which control bowel evacuation. Many factors may pervert the normal reflexes, causing finally chronic constipation. Among them are: nervous fatigue and tension, improper intake of fluid, improper dietary habits, failure to respond to the call to stool, lack of physical exercise and abuse of the intestinal tract through excessive use of laxatives.[2]

Correction of constipation logically, therefore, lies in the suitable adjustment of these factors. The characteristics of Metamucil permit the correction of most of these factors: it provides bulk; it demands adequate intake of fluids (one glass with Metamucil powder, one glass after each dose); it increases the physiologic demand to evacuate; and it does not establish a laxative "habit." Metamucil, in addition, is inert, and also nonirritating and nonallergenic.

Dosage Considerations

The average adult dose is one rounded teaspoonful of Metamucil powder in a glass of cool water, milk or fruit juice, followed by an additional glass of fluid if indicated.

Metamucil is the highly refined mucilloid of Plantago ovata (50%), a seed of the psyllium group, combined with dextrose (50%) as a dispersing agent. It is supplied in containers of 4, 8 and 16 ounces. Metamucil is accepted by the Council on Pharmacy and Chemistry of the American Medical Association. G. D. Searle & Co., Research in the Service of Medicine.

---

1. Best, C. H., and Taylor, N. B.: The Physiological Basis of Medical Practice: A Text in Applied Physiology, ed. 5, Baltimore, The Williams & Wilkins Company, 1950, pp. 579-583.

2. Bargen, J. A.: A Method of Improving Function of the Bowel, Gastroenterology *13*:275 (Oct.) 1949.

The Pope-Yell County Medical Society met September 9th in Russellville. Walter A. Brooks spoke on "Fluid Balance."

The Arkansas Radiological Society met in Little Rock September 3, 1954. Hosts for the meeting were Wm. J. Rhinehart, Joe A. Norton and G. G. Regnier of Little Rock.

Dinner was followed by a business session. The application of Augustus Baker of El Dorado, was approved for membership in the Society. Following the business meeting, an interesting film reading session was held, moderated by Damon Blake, Senior Resident in Radiology at the University of Arkansas School of Medicine.

Joe A. Norton, Secretary-Treasurer.

AUXILIARY NEWS

An Invitation to You From The Southern Medical Auxiliary

Mrs. George D. Feldner, President of the Woman's Auxiliary to the Southern Medical Association extends a cordial invitation to you to attend the annual convention to be held in St. Louis, Mo., November 8-11.

All business meetings of the Auxiliary will be held at the Statler Hotel. Registration will also be at the Statler as will the state exhibits.

Social functions and meetings are being planned so as to allow time for visiting with friends, enjoying the convention with your husbands and for shopping, etc.

On Monday afternoon there will be a tea—an opportunity for you to "know the other members better."

Tuesday, 10:00 a. m., the general meeting and at 1:00 p. m. the Doctor's Day luncheon when prizes will be awarded in the annual Doctor's Day Contest. Many original and unique innovations are being planned for this luncheon which will be held in the ballroom of the Statler Hotel. All Auxiliary members and their husbands are invited.

Wednesday, 9:30 a. m., is the closing session of the meeting. Mrs. George Turner, President of the Woman's Auxiliary to the American Medical Association, will be guest speaker at this time, and Mrs. Louis K. Hundley, Pine Bluff, Arkansas, will be installed as President of the Southern Auxiliary.

Wednesday evening is the annual dinner of the Southern Medical Association in the Gold Room of the Jefferson Hotel.

Mrs. A. H. Conrad, Jr., President of the St. Louis Auxiliary and Mrs. E. S. Beckette, General Chairman of Arrangements have advised us that St. Louis is anticipating the pleasure of your visit and committees are hard at work on plans for your enjoyment while in Missouri.

Hotel reservations can be made through the Housing Bureau, Southern Medical Association, 911 Locust Street (Room 406), St. Louis, Mo.

Make your plans now for you and your husband to come to St. Louis. Enjoy the fun and good fellowship for which Southern is noted. Meet your old friends; make new ones; get to "Know the other member better."

Even if your husband isn't a member of the Association, we want you both to come visit with us. You are welcome!

MEDICAL ASSISTANTS MEETING

Medical assistants from all over Arkansas will meet November 13 and 14 to organize a state association. The only activity scheduled for Saturday, November 13, will be advance registration from 4:00 to 7:00 p. m. at the Hotel Marion in Little Rock. The program will begin with breakfast at 8:00 a. m. Sunday the 14th. Dale Alford, chairman of the Public Relations Committee of the Arkansas Medical Society, will address the group at breakfast. Following will be a business session—including the appointment of nominating committees, discussion of objectives, plan of organization, etc.

At 11:30 a devotional service will be held. At luncheon (12:30) the president of the Kansas Medical Assistants Society will speak. Another business session will be held beginning at 2:00 p. m. at which the president of the Michigan State Medical Assistants Society will talk on ethics and on the organizations' work in general. The election of officers, appointment of committees, discussion of annual meetings (to be held preceding State Medical Society meetings) will be on the agenda for this session.

Doctors are urged to make it possible for their medical assistant to attend this meeting to participate and to help decide the direction and policy of the new organization. The Medical Society Public Relations Committee is cooperating with the Medical Assistants in the belief that they are a most important factor in Medical Public Relations.

U. C. MEDICAL CENTER LIBRARY
NOV 1 3 1954
San Francisco, 22

NOVEMBER 1954

THE JOURNAL OF THE ARKANSAS MEDICAL SOCIETY

VOL. LI No. 6

FORT SMITH, ARKANSAS

consider
ILOTYCIN
(ERYTHROMYCIN, LILLY)
FIRST

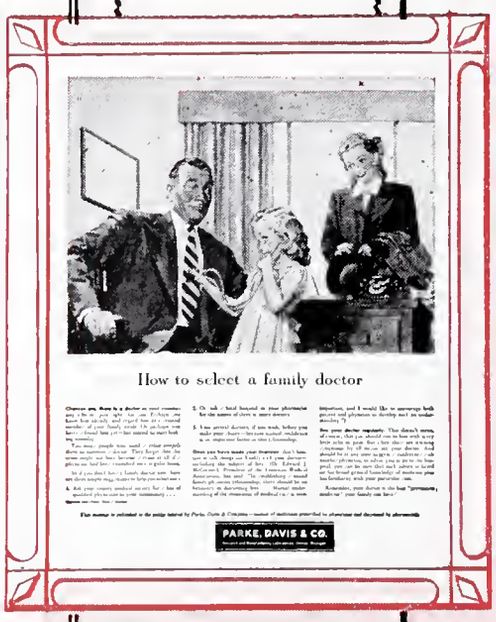
...because 'Ilotycin' is notably safe

No allergic reactions to 'Ilotycin' have been reported in the literature. Staphylococcus enteritis, anorectal complications, moniliasis, and avitaminosis have not been encountered.

Available in tablets, pediatric suspension, and I.V. ampoules.

Lilly

Let these experts on relexing show you
how to live with HIGH BLOOD PRESSURE
PARKE, DAVIS & CO.

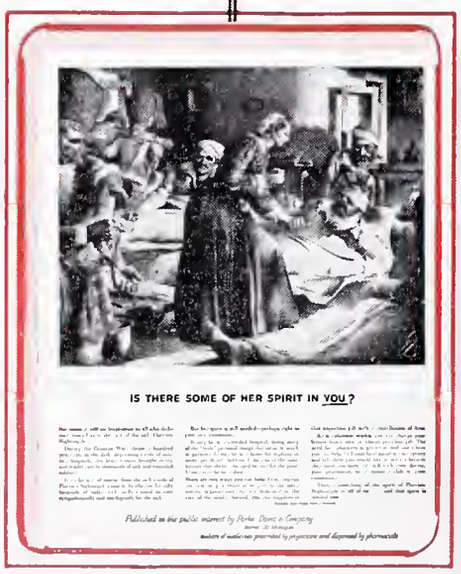

How to select a family doctor
PARKE, DAVIS & CO.

DO YOU KNOW THIS M
PARKE, DAVIS

Wh

Theres a brighter outlook now for the child with EPILEPSY...
PARKE, DAVIS & COMPANY

How mony of these people
need o doctor?
PARKE, DAVIS & COMPANY


IS THERE SOME OF HER SPIRIT IN YOU?

PARKE-DAVIS speaks to the public...

HAT people think about doctors is etty important to the future of the actice of medicine in this country.

Can the power and influence of lvertising—the *right kind* of adver-ing—be employed to bring home people what the physician of today n really do for them, if they'll only ve him the opportunity?

Parke, Davis & Company's answer this question is their "See Your octor" advertising program which ey started twenty-six years ago and ve been carrying on ever since. ch message in this continuing series nphasizes the same major theme: *e importance of prompt and proper edical care.*

No products are mentioned; that the province and responsibility of e physician.

Because these messages are all "picture stories" that dramatize the informative and serious material they present, they are among the best-read advertisements being published today. Above everything else, we try for plausible, believable messages that will nudge the reader into action without either raising false hopes or scaring him. We want him to have not only increased confidence in his doctor, but in the professional background and skill of the pharmacist who fills the prescription, and in the medicine itself.

We naturally hope that the reader will come to know and recognize Parke-Davis as a leader in a fundamental American industry, and to associate our name and label with manufacturing skill, careful testing, and enlightened research.

A program of this kind, if it is to do the greatest good, must be brought to the attention of millions of people. That is why the "See Your Doctor" messages have appeared and are currently published in the SATURDAY EVENING POST, LIFE, TIME, NEWSWEEK, TODAY'S HEALTH, and other leading magazines.

While the broad problem is one which admittedly challenges the skill and resourcefulness of many organizations that have the interest of Medicine at heart, Parke-Davis is proud to have a part in pioneering and developing a type of advertising approach which is proving increasingly effective in meeting this challenge. *PARKE, DAVIS & COMPANY, DETROIT 32, MICHIGAN.*

MEDICAMENTA VERA
PD & CO.

THE

Journal

OF THE

Arkansas Medical Society

Owned by

THE ARKANSAS MEDICAL SOCIETY

And Published Under Direction of the Council

FOUNT RICHARDSON, M.D., Editor

316 West Dickson Street Fayetteville, Arkansas

MR. PAUL C. SCHAEFER, Business Manager

215 Kelley Bldg. Fort Smith, Arkansas

The Advertising policy of this JOURNAL *is governed by the rules of the Council on Pharmacy and Chemistry of the American Medical Association.*

EXCLUSIVE PUBLICATION—Articles are accepted for publication on the conditions that they are contributed solely to this JOURNAL.

COPYRIGHT, 1954—By The JOURNAL *of the Arkansas Medical Society.*

NEWS—Our readers are requested to send in items of news, also marked copies of newspapers containing matter of interest to the membership.

OFFICERS OF THE ARKANSAS MEDICAL SOCIETY

W. R. BROOKSHER, President....Fort Smith
L. H. McDANIEL, President-Elect....Tyronza
T. P. FOLTZ, First Vice-President....Fort Smith
ELDON FAIRLEY, Second Vice-President....Wilson
R. H. WHITEHEAD, SR., Third Vice-President....DeWitt
J. J. MONFORT, Secretary....Batesville
DANIEL H. AUTRY, Treasurer....Little Rock
T. DUEL BROWN, Speaker, House of Delegates....Little Rock
C. C. LONG, Vice-Speaker....Ozark
MR. PAUL C. SCHAEFER, Executive Secretary
215 Kelley Bldg., Fort Smith

COUNCILORS

First District—JOE VERSER....Harrisburg
Second District—HUGH R. EDWARDS....Searcy
Third District—J. MAX ROY....Forrest City
Fourth District—L. K. HUNDLEY, Chairman....Pine Bluff
Fifth District—D. E. WHITE....El Dorado
Sixth District—HARRY E. MURRY....Texarkana
Seventh District—H. KING WADE, JR....Hot Springs
Eighth District—H. ELVIN SHUFFIELD....Little Rock
Ninth District—FOUNT RICHARDSON....Fayetteville
Tenth District—J. M. KOLB....Clarksville

VICE-COUNCILORS

First District—WAYNE WORKMAN....Blytheville
Second District—JOHN SNEED....Conway
Third District—J. P. WILLIAMS, JR....Brinkley
Fourth District—H. W. THOMAS....Dermott
Fifth District—GEORGE BURTON....El Dorado
Sixth District—CHARLES YARBOROUGH....Texarkana
Seventh District—RANDOLPH ELLIS....Malvern
Eighth District—ROBERT D. JONES....Little Rock
Ninth District—LEE A. DEAN....Rogers
Tenth District—LOUIE A. WHITTAKER....Fort Smith

Notice on Form 3578-P to be sent to the Arkansas Medical Society, 215 Kelley Building, Fort Smith, Arkansas. Published monthly under direction of the Council, Arkansas Medical Society, at Fort Smith, Arkansas. Vol. LI, No. 6. Subscriptions $3.00 a year. Single copies, 50 cents. Entered as second-class matter, Sept. 23, 1947, at the post office at Fort Smith, Arkansas, under the Act of Congress of March, 1879. Acceptance for mailing at special rate of postage provided for in Section 1103, Act of October 3, 1917, authorized August 1, 1918.

• SPECIAL FEATURES

Committee on Cancer Control.... 131

Factors Predisposing to Hemorrhagic Disease of the Newborn.... 132

Psychiatry and Religion.... 134

Preventive Program for Retrolental Fibroplasia in Arkansas.... 140

• FEATURES

Coming Attractions.... 144

Committees of the Arkansas Medical Society.... 145

Obituary.... 145

Appointed to U. of A. Faculty.... 145

Arkansas Traveling.... 146

Editorial.... 147

Public Relations.... 148

Tuberculosis Abstracts.... 149

Personals and News Items.... 151

Proceedings of Societies.... 152

Woman's Auxiliary News.... 154

The JOURNAL
OF THE ARKANSAS MEDICAL SOCIETY
PUBLISHED MONTHLY UNDER DIRECTION OF THE COUNCIL

Vol. LI November, 1954 No. 6

Committee on Cancer Control

C. A. ARCHER, Chairman, Conway

THE SEX HORMONES IN ADVANCED BREAST CANCER

Lewison and Chambers in a recent issue of the New England Journal of Medicine give an analysis of 80 patients with advanced breast cancer who were treated with steroids. The cases selected were considered beyond aid of the customary methods of treatment. Androgens were administered to those cases with bone or soft-tissue lesions irrespective of the age of the patient. Estrogens were given in postmenopausal cases irrespective of the age of the patient. The steroids were administered as sole therapy to all patients for a minimum of three months.

Subjectively favorable results were reported in 80% of 57 patients receiving androgens and in 52% of 40 patients receiving estrogens. Bone metastatic lesions showed objective improvement in 25% of 32 patients receiving androgens and in 27% of 11 patients receiving estrogens. Soft tissue lesions showed objective improvement in 35% of 48 patients receiving androgens and in 32% of 34 patients receiving estrogens.

The clinical response is not predictable. The estrogens seem to principally benefit the postmenopausal patients, while the androgens may help regardless of age.

While not a "cure," they do offer gratifying benefits in those patients who are beyond hope of conventional therapy.

FACTORS PREDISPOSING TO HEMORRHAGIC DISEASE OF THE NEWBORN

WILBUR G. LAWSON, Capt. M.C.,* † New Orleans, Louisiana

The incidence of hemorrhagic disease of the newborn is quite small, but it is a regularly recurring problem because of the frequency of possible cases.[1] Spurious bleeding noted in the newborn is often unrelated to a deficient autohemostatic mechanism. Disregard for this fact has seriously influenced the interpretations of case material in some published studies. There is a legitimate cause for confusion in some cases because of the mixed factors involved in the onset of spontaneous bleeding.

The new born is justly entitled to having a cephalhematoma or intracranial hemorrhage following bony dystocia, just as the adult may suffer a similar lesion from appropriate trauma. Septicemia in the newborn produces hemorrhage just as it may in the adult.[2] Anoxia produces hemorrhage in either, irrespective of the hemostatic mechanism. Sudden withdrawal of estrogen stimulation occurring at birth results in occasional vaginal bleeding in the female infant by the similar response seen in the adult. Blood swallowed by the infant during delivery produces bloody vomitus and tarry stools, if not fresh blood in the stools. Such factors as these must then be eliminated from consideration and the problem established as that rare occurrence of spontaneous, and as yet idiopathic, hemorrhage occurring in the early days of the first postnatal week.

The factor of low available prothrombin, proven to occur in the newborn through the same period when bleeding occurs, is a familiar element for consideration. The pattern of the curve obtained by plotting the available prothrombin through the first week has caused a strong emphasis to be placed on correcting this defect. The deficiency has been variously measured at 20-40% of adult normal. Vitamin K, which is known to increase available prothrombin, has been used extensively. The effect of making this change is still of questionable benefit. Conflicting results are reported and certainly one must doubt that a prothrombin defect alone is the problem.

The general description of hemorrhagic disease of the newborn includes a prolonged coagulation time and a normal bleeding time, clot retraction and platelet count. There has been rather single-minded attention to the blood chemical factors in the investigation of this problem. There is better than average agreement that, A. the total prothrombin level is much below the adult. B. there is a post-natal drop in available prothrombin with a return to previous levels by the fifth day, and C. vitamin K increases available prothrombin levels quickly. Most all concur that fresh whole blood given intravenously is the most effective treatment irrespective of vitamin K.

The question of what initiates the hemorrhage is of primary concern. There must be a disruption of normal vascular integrity. It is a common practice, in older patients, to neutralize the chemical hemostatic mechanism by the use of heparin or dicoumarol. Bleeding does not occur in these patients unless some form of trauma breaks vascular continuity. I cannot attribute the occurrence of hemorrhagic disease solely to a blood chemical defect known to be normally present in uncomplicated infants. The findings are not notably worse in those infants severely affected by the condition.

The role of capillary integrity in hemorrhagic disease has, in many descriptions, been passed over with the blithe remark that "increased capillary fragility of the premature and newborn predisposes to hemorrhagic tendencies." I wish to report results of a study designed to find the incidence of increased capillary fragility in prematures, and the effect of rutin (vitamin P) given orally to prematures.

Rutin is a yellow crystalline glucoside refined from many common plants (tobacco, buck-wheat, tomatoes, and elderberry) and is related to ascorbic acid both in occurrence and function.[3] It is thought that rutin is closely concerned with capillary wall resistance through an antihyaluronidase action. Studies in adults, using 20 mgm. doses three times daily, have suggested that there is significant improvement in disease processes causing increased capillary fragility.[4, 5] Toxicity is absent. High doses have been given for as long as 16 months, and in amounts as high as 15 grams daily, without ill effect.

Serial determinations of hemoglobin, bleeding-clotting times and capillary fragility were done on 41 prematures varying in weight from 2 pounds, 8 ounces to 5 pounds, 5 ounces at birth. Patients were taken in order of birth and the initial readings made on the first morning after

* Chief, Pediatric Section, U. S. Army Hospital, Camp Leroy Johnson, Louisiana.
† Formerly Assistant Professor of Pediatrics, University of Arkansas School of Medicine.
Read before the Pediatric Section at the Seventy-eighth Annual Session, Arkansas Medical Society, Fort Smith, April 19, 1954.

birth. Subsequent readings were made at 48 hours and at one week of age. Alternate patients were given rutin (Abbott-25 mgm./cc. in piperazine) 25 mgm. orally every twelve hours for fourteen doses. Vitamin K (Synkamin) 2 mgm. every eight hours for three doses, was given subcutaneously to all patients, and standard premature care given. All determinations were made by the author in order to maintain consistent interpretation.

Hemoglobin was determined with the Hellige-Sahli hemoglobinometer. Bleeding times were measured after a 1-2 mm. deep stab wound was made in a great toe. Clotting times were measured by the formation of a fibrin string in a blood droplet obtained from the free flowing wound.

Petechial counts were made using the Rexall negative pressure petechiometer.[6, 7] The inner surface of the thigh was used in all cases. The instrument was adjusted to exert 24 cm. Hg negative pressure. Suction was applied for one minute and the skin area then examined under low power magnification after five minutes. Pressure was applied to the area with a plastic slide supplied with the instrument to blanch the skin and help demonstrate petechiae.

Twenty patients were treated with rutin, and twenty-one were not. Four untreated and two treated patients died. None of the deaths could be attributed to hemorrhage and no significance is given to the difference in mortality rate.

Petechial counts were positive in three treated patients. One was positive at birth and negative at 48 hours of life. Two patients developed positive petechial counts after one week of treatment.

Petechial counts were positive in four of the untreated patients. One, who had a positive count at birth, had a negative count by 48 hours of life. Another, having a positive count at birth, died before the 48-hour count could be made. Two patients having had negative counts at birth were found to have positive counts at one week of age.

There was no correlation of hemoglobin level or bleeding-clotting times to the petechial counts. Many of the patients examined had extensive bruising and scattered petechial formation in regions that had been subjected to birth pressure but only one of these patients had a positive petechial count.

Discussion

The very low incidence of increased capillary fragility as measured by the negative pressure technique is remarkable. The accuracy of the instrument used was checked by direct pressure readings with a mercury manometer. The negative pressure exerted was constantly 24 cm. mercury when set at the maximum tension. The adult patient should not normally develop more than two petechiae if the negative pressure is set at 20 cm. mercury. In spite of using the presence of one petechia as the basis for a positive test, only seven of forty-one prematures had positive results.

Trial readings were made on several adults. One patient who had infectious hepatitis and another who had familiar increased capillary fragility developed large numbers of petechiae in the test areas. The patient ill with infectious hepatitis developed increasing capillary resistance as the hepatitis diminished and subsequently had a negative result in the convalescent period.

Possible errors due to the use of different skin areas, and the reduced pressure from redundant skin were minimized by the consistent use of the inner thigh region of the premature for the determinations.

The embryological sequence of development of the embryo suggests that endothelial structures, including the capillary system should be well developed in comparison to other tissue systems of the premature. Negative pressure studies appear to confirm in part that the inherent capillary fragility of the newborn is actually low. The hemorrhagic tendency of the newborn might thus be blamed on immaturity of the supporting stroma, allowing disproportionate stress to be applied to the capillary bed during trauma. Once disruption of capillary integrity occurs there is an abnormal amount of bleeding because of the coagulation defect.

The measures used at the present, vitamin K for prevention, and fresh whole blood for treatment, are helpful but still too often futile. The administration of vitamin P to the patients in this series did not appear to contribute to their well being. I would expect however that this treatment is also given too late when administered to the newborn. The development of sound capillary integrity requires more time than the course of hemorrhagic disease allows. When used on adults having hypertension and increased capillary fragility it has required three to twelve weeks of rutin therapy to produce normal capillary resistance.

It would appear worthwhile to administer rutin to a group of pregnant women during the last trimester of pregnancy in order to study the effect on their infants of having optimal conditions for capillary growth. Perhaps this measure, along with the correction of the coagulation defect of

the newborn, would serve to advance the safety of the newborn against spontaneous bleeding in the first week of life.

BIBLIOGRAPHY

1. Clifford, S. H. Hemorrhagic Disease of the Newborn, J. Pediat. 14:333, 1939.
2. Round Table Discussion on Hemorrhage in the Newborn Infant. J. Pediat. 20:637, 1942.
3. Shanno, R. L. A New Drug for the Treatment of Increased Capillary Fragility. Am. J. Med. Sc. 211:539, 1946.
4. Rapaport, H. G. Vitamin P and Capillary Fragility. J. Pediat. 18:321, 1941.
5. Griffin, J. Q. and Lindauer, M. A. Increased Capillary Fragility in Hypertension: Incidence, Complications, and Treatment. Am. Heart J. 28:758, 1944.
6. Brown, Edward E. Evaluation of a New Capillary Resistometer: The Petechiometer. J. Lab. & Clin. Med. 34:1714, 1949.
7. Weinberg, James I. The Petechiometer: A Simple Method for Measuring Capillary Fragility. J. Med. Assoc. Georgia, Sept. 1949.

PSYCHIATRY AND RELIGION

EARL PARSONS, Little Rock

A gradual, if cautious, trend of conciliation between religion and psychiatry has become evident during recent years. Thoughtful leaders in both fields have partially bridged the gap by according due respect each to the worth and effectiveness of the other. At least one denomination (Episcopal) requires psychiatric examination and psychological testing prior to ordination to the ministry. Nevertheless, there exist misconceptions which prevent some patients from seeking psychiatric help and which cause some physicians to be hesitant in referring patients to a psychiatrist for fear they may literally "lose their religion." This fear may seem to be naive; yet it is surprisingly prevalent, and it is the purpose of this paper to respond to that misconception.

The situation is based partially upon fact. There are, unfortunately, some psychiatrists who insist that religion is at best an illusion; at worst, a delusion. Psychiatrists of this type set themselves up as little gods who have the only answer to mental health. On the other side of the picture, there are churches that are deeply antagonistic to psychiatry in general and to psychoanalysis in particular. They too offer the only answer and the only way to salvation.

Basically, however, there is no real conflict. A sophisticated psychiatrist will welcome, even encourage, help from the clergy in handling the spiritual needs of his patients. On the other hand, churches that are not fearful of inspection or thinking on the part of their members will welcome psychiatric help for members for whom pastoral counseling has proved to be ineffective. And this is the crux of the matter. Few if any patients treated by the psychiatrist (there have been none in my personal experience) have not been exposed to some religious teachings—frequently an overdose. Clerics who are antagonistic to psychiatry are actually complaining because the psychiatrist is seeing someone whom they, or someone of their type, have failed to help with religious counsel. As a matter of fact, it often happens that a patient who has rejected the church, or who has been rejected by it, will use psychotherapy as an avenue of re-entry into some other church following treatment. Many psychotherapists consider their treatment incomplete unless the patient does obtain a healthier concept of his spiritual needs.

The conflict between psychiatry and religion is based upon orientation and superficial aims rather than upon any fundamental differences. Although the two fields are in direct economic competition with each other, the well-to-do in each are not afraid of the competition, but indeed encourage it. For stated in a different manner and from a different frame of reference, there is little material found in dynamic psychiatry—therapeutic or philosophic—that cannot be paralleled in the Scriptures. The spheres of orientation may vary, but the goals are the same. It is the methodology which is at variance.

The cleric would teach one how to adjust to the world as he would like for it to be. The psychiatrist would coach, teach, and encourage his patient to view and adjust to the world as it really is. The psychiatrist does not object to aiming for a better and more Christlike world; but until that objective is obtained, he orients his therapy to cope with present-day realities.

Many theologians subscribe to the Augustian concept that man must love in four directions. First, he must love above himself; i. e., he must

love God. Second, he must love himself. Third, he must love his neighbor as himself. Finally, he must love beneath himself; that is, he must love God's sub-human creatures (dogs, flowers, trees, etc.).

Philosophically, the psychiatrist will agree with this theory of love. But practically and therapeutically, in dealing with his patients, he will rearrange the order thus: First, love of one's self and love of creatures beneath one's self. Then love of others, and finally, God. This arrangement is made simply because it is quicker and easier that way. Love of God and of neighbor cannot be achieved—sincerely, that is—before a healthy love and esteem of one's self has been established, any more than a starving man can share a morsel of food "lovingly." For the average person, certainly the average neurotic, such heroics are only remotely likely. I believe that it is possible to love God and others more than one's self but not **first.** If one isn't loved, he simply can't believe God will love him.

In teaching a supreme love of God, the cleric may say simply, "We love Him because he first loved us." But the psychiatrist knows that very few, if any, neurotics can believe this; nor will the facts of their lives bear it out. Any real love in the past history of the neurotic is most difficult to find, and pitifully small if it is found. The essence of psychiatric treatment is to help the patient to see that earlier experiences—involving lack of love and trust—tend to cause him to reject later opportunities for love, partly because he cannot believe in it, and partly because he wants to hold on to his nursing of wounds and hates and hostilities.

The patient must learn that he can have love, but what is more important, he must learn that he has to earn it. In the process of treatment he buys love and friendship in terms of fees, time, psychic pain, and the relinquishing of his cherished hates and ideas. Then, and only then, can he appreciate the concept "We love Him because He first loved us."

Every child is born helpless and with an inherent need to trust. In his infant state, before he can think or speak or act for himself, the child must look to those in charge of his care (parents, nursemaid, grandparents, etc.) for all of the needs and requirements necessary for his survival and comfort. Ideally, these people respond with their own need to love and protect, making the relationship mutually tender and satisfying. Love begets love. This sense of confidence in the parents (or parental substitutes) must grow, so that it nourishes and broadens the personality until the child arrives at a healthy acceptance of himself and the world about him without undue burdens or guilt or fear or hostility. This need to trust is inexorably present, even when those people who care for the child are not worthy of trust or equal to it, in which instance the inclination cannot be erased but is driven underground, to be hidden behind defenses. Unfortunately, many mothers and fathers fail to live up to the greeting card ideal! It is in this blocking of trust, this tragic denial of it, that neurosis has its beginnings. And one telltale mark of the neurotic is his tendency to place trust in people and activities that are sure to fail him. These repeated failures make it very unlikely that the neurotic can conceive of a trusting, loving, or reliable God. It is these people who "envy" others religious faith.

Frustration of the need to trust in a child breeds feelings of excessive anxiety, which in turn, warp and impede development of the whole personality. There is engendered a feeling of helplessness, causing sadistic reactions (hate and fury) in an active child; or masochistic reactions (despondency and apathy) in the passive child. These are the crippling effects of undue anxiety, brought about by the prolonged lack of love and cooperation between parent and child.

Many children are not wanted at all, usually because the parents are too immature or unwilling to assume the responsibility of parenthood. Or the child may have been wanted, but only to satisfy some selfish or unrealistic desire on the part of the parents—for instance, to bind together a marriage that seemed headed for failure. In any event, it is very unlikely that a child born under such circumstances will be warmly accepted and loved. His needs are not responded to naturally and without constraint, and he becomes the victim of frustration and anxiety. He arouses in the parents anxieties which amplify the infantile anxieties, and thus a vicious circle is formed. The close and genuine affinity between child and parents (particularly between child and mother) is lacking from the beginning. In the process of psychotherapy the patient learns—or at least speculates upon—the personal problems of his parents; the problems which erected the barriers in the first place. In this way he learns that something was wrong with mamma and daddy, and not with himself. (Unfortunately, the rejected child considers "What's wrong with me." From there begins the self doubts, the lack of confidence, and the many other feelings of inferiority.)

From excessive anxieties both on the part of the parents and the child, stem a number of other disorders which hamper and impair the development of the personality. One of these is the feeling of guilt.

If parental standards of "good" behavior are confused and unstable—inconsistent, too restrictive, or too indulgent—the child not only becomes affected by his parents' feelings of extreme uneasiness, but he also finds that their demands contradict his own natural needs. However, because of his sense of utter dependency, the child who wishes to please his parents will drive underground his own desires which do not meet with parental sanction. But they do not disappear. They are banished from consciousness, but remain imbedded in the unconscious, unsolved and arrested on an infantile level, later to cause trouble when aroused by some internal or external provocation. At this later date the giving vent to or expression of previously suppressed feelings may be very acceptable, even welcomed, by the adult associates in definite contradiction of the attitude of the parents years ago. However, the patient has so long assumed he would be criticized or punished that he continues to suppress these normal feelings that the non-neurotic may freely and beneficially express. This concept is also applicable to the sphere of religion in that the neurotic's concept of God is patterned after his concept of his parents. The neurotic gives nothing and expects nothing from the Lord if he had ungiving parents. Conversely, if his parents were too indulgent, he expects the Lord to deliver on a platter and reacts with rage and disillusionment when he learns that the Lord helps only those who help themselves.

Just as the child blames his parents, the neurotic adult blames the church or the Lord for his inadequacies, his fears of having fun, or his inability to afford to have fun. Many times neurotics explain their lack of action in an effort to enjoy life by saying it is against their religion. Almost invariably, upon examination, it becomes obvious that in addition to their religious teachings, they are afraid of present day punishment as much as the wrath of God. Or oftentimes that they simply cannot afford to do whatever they have labeled sinful!

It is pathetically amusing the number of times that we must admit that if given special permission direct from the Lord to commit a lot of things we consider sins we would still avoid them because of most earthy reasons—such as irate husbands, policemen, public opinion, and shortage of cash. The expression that the wages of sin is death may be a very real and effective one, but the expense of sinning is also a very real deterrent. Once a patient is able to face this, he is able to quit blaming the church for the way he is living and perhaps thank the church for giving him a more acceptable alibi for the way he lives.

The good conscience is a helpful factor in the process of maturation, but the habitually bad conscience is like a heavy load, hampering and retarding emotional growth and progress. It does not indicate inner badness; it is rather the inevitable outcome of lack of love and sincere cooperation between a child and his parents.

A child's conscience, which mirrors his parents' expectations and standards of conduct, not only represses unsocial and antisocial inclinations, but it can also preclude the nurturing of positive, constructive tendencies. For example, a child who has made repeated bids for parental acceptance and has been rejected and deprived time after time will know nothing of love and tenderness because he has never experienced them himself. Nor will he be able to expect or believe in a different reaction from God. It is these people who often say "I wish I could believe."

But perhaps the most tragic results of excessive anxiety in a child is the inability to resolve the conflicts of his infantile sexual drives. This is a phase which requires delicate manipulation and puts to test the powers of tender cooperation and rapport. There is a very thin line between primitive sexual excitement and the sublimated experience of tender love and affection. Too much coddling can cause sexual arousal not only in the child, but also in the adult.

Since primitive sexual drives are present in an embryonic state from early childhood on, the child expresses these feelings in various ways: by curiosity, by exhibitionism, by masturbation. These activities are natural and harmless enough, unless adults make a great deal of fuss about them. However, when parents become unduly ashamed and agitated by the child's natural manifestations in the realm of sex, the child will try to suppress his drives and, because he is made to feel ashamed and guilty, his sexual impulses will assume undue and unhealthy intensity and emphasis.

When a child suffers from lack of love and understanding, he can fall prey to deeply disturbing and disastrous conflicts of passion and guilt. For example, incestuous feelings toward a parent or sibling will be more intense, and feelings of hatred and murder against a rival will be

more violent in the child who has been emotionally estranged from his parents. Any unfortunate experience involving sex—such as seduction or falling victim to the selfish gratification of an older person's passion—can cause a child to become so engrossed in sexual or murderous motives that these motives become compulsive and incapable of being satisfied, since sexual lust can never become a substitute for the original need for love and trust. Psychotherapy is not the only way to reveal this or to remedy it, but it is far more effective than to simply pass edicts against sex as some special degree of sin.

It must be remembered, however, that a patient does not come to a psychiatrist to be indoctrinated in religion or philosophy. He looks to the psychiatrist for aid in solving his difficulties in living and in overcoming the symptoms which are causing him discomfort. It is the office of the psychiatrist to direct treatment to alleviate these particular difficulties, all within the framework of the patient's own social and economic status, which is often quite different from that of the therapist.

These therapeutic objectives are attained, ideally, by a process of the unlearning of erroneous or faulty or unusable concepts. They are arrived at gradually, as the patient gains freedom from fear and anxieties and from his involvements with jealousy and hatred and greed. These goals will be realized in action when the patient has developed his capacity for self-realization, when he is capable of entering into a satisfactory and lasting relationship with others, and when he can love maturely and accept mature love himself. And in order to love maturely, he must first have a healthy and stable self-esteem, which in turn permits healthy and relatively unselfish concern for the loved one's welfare and happiness as a person in his own right.

The process of psychotherapy is to all intent and purposes that of re-education and reorientation to the fact that the patient is no longer a helpless child dependent on mixed up parents, but a socially self-sufficient individual, free to pick and choose companions and loved ones who are capable of reacting quite differently from those associated with his early childhood. The neurotic cannot realize this fact, nor is he able to accept it without help from someone who can make up for his lack of basic personal education. Incidentally, this is a basic justification for psychotherapy in the scheme of both religion and general medicine. The busy preacher and the general medical doctor simply does not have the time necessary to devote to overcoming the real neurosis. In my personal experience, I have met many ministers and general medical practitioners who in my opinion would be excellent psychotherapists. But whereas I see six or eight people each day, they must see many times that number.

The end result of successful treatment enables a person to employ his talents, his faculties and abilities, to obtain satisfaction within his own socially realistic and self-established set of values. Furthermore, it should enable him to do anything or say anything that he really feels, short of endangering himself or someone else, running afoul of the law, or being ostracized by his own social group. He recognizes that the world continues to change and that his parents and early teachers are a generation away from the present state of reality, and that some scriptural passages are many generations away.

As we have seen, the neurotic personality is generally ruled by a tyrannical conscience. In psychotherapeutic treatment the conscience is handled or made less prohibiting simply (simply said, difficulty done) by re-examining and deciding which part of the "little voice" belongs to the patient, and which comes from his parents or teachers. If it belongs to either of the latter, then he must examine again to determine whether or not the prohibiting factor is still pertinent in his present-day social and individual status. The "good" boy of six is accepted with praise; but, without change, he is ostracized as a sissy at sixteen, and considered pitiful at thirty-six.

Inevitably in the course of each patient's treatment there will be two elements with which the therapist must deal. One is his attitude toward his patient's religion. The other is his own personal philosophy. The problems posed by these two constitutents are most delicate and require skill in handling.

In the case of the patient's religion, the psychiatrist must distinguish between delusional and nondelusional elements. He must determine what is genuine and what is hypocrisy or idolatry. The latter elements the psychiatrist must endeavor to uncover and uproot. But truths of this nature are very difficult to determine. It is often necessary to seek the authority in the field of the religion to which a patient belongs. For example, if a patient seems to adhere steadfastly to certain religious ideas which seem to the therapist to be delusional, he should consult a minister of the patient's faith. If the minister assures him that the patient's beliefs are common and acceptable in that particular church, it can be assumed that for the patient the thinking is not delusional per se.

It is, of course, quite difficult to get patients to face, accept, and satisfy their animal needs. However, it is remarkable how much more difficult it is to get the same patients to face and satisfy their spiritual needs. It is for this reason that orthodox Freudian therapy or any therapy that stops short of reconciling the two needs, is faulty and incomplete. Just as is the ministry incomplete which does not recognize and permit instinctual qualifications.

The matter of the psychotherapist's personal philosophy is important because it will unconsciously guide and shape the goal toward which the therapy is directed. Naturally, anyone practicing psychotherapy should be analyzed or at least receive a searching personal study to prevent projecting unhealthy personal prejudicies. However, even with a complete analysis it is unlikely that all projection will be eliminated. That is why a patient should investigate his therapist carefully. He need not be ideal from every angle, but if he is a complete misfit in any sphere or is poorly adjusted in many, then he should be rejected—the therapist, not the therapy—just as a cleric—and not the religion—should be rejected if the cleric is a complete misfit. This in itself is part of therapy, to learn to divorce the man from the philosophy. It is a basic element of psychotherapy to think and act for one's self.

The therapist is a human being and as such he cannot completely free himself from his own beliefs and philosophy in therapy, and he must vigilantly guard against projecting these personal feelings and tenets upon his patients. It is not easy! (And it is perhaps even more difficult for the cleric, who has more sanction to "act for" or at least "work for" God.) All of which indicates that completely objective therapy is not probable. The psychiatrist must direct and explain, and his own personal viewpoint will inevitably enter into the directions and the explanations. Having been honest in his admission that he functions from a fallible and human viewpoint, he must proceed to direct his patient as he thinks best for the ultimate welfare of the patient. By so doing, the patient also learns to recognize and handle his own prejudices. But more important, he learns to take risks and not to be overwhelmed by criticism.

It is frequently the directive measures which cause criticism to the psychiatrist. For instance, one commonly hears the somewhat irresponsible remark that some psychiatrist suggested that Mrs. X have an affair. Such recommendations are not made offhand. How the patient lives has a great deal of bearing upon what he can do. For instance, a young woman in the country club set might do something a little unusual or startling which would cause only a minor flurry of comment in her own group. On the other hand, a young woman living in a narrow, small town might do the same thing and be confronted with complete disaster and disgrace. The same analogy may be applied to the age of the person. What would be a disastrous act at sixteen may be commonplace and healthy at twenty-six. The psychiatrist should recognize and color his recommendations by the fact that what might be psychologically or personally beneficial or just a lot of fun to the patient could easily be disastrous socially or vocationally as a result; and as an end result, cause more harm than good.

It is interesting to note that there are almost as many "schools" of psychiatry as there are religious denominations—each in some way conflicting with the other. The reason for the division is that each system is more applicable to an age or a state than the others. An adolescent patient, or one who has regressed to the adolescent period, or who has stopped growing in the teens, responds to Freudian concepts, whereas therapy based on an Adlerian or a Jungian approach would be of little worth in helping that particular patient to adjust. Similarly, the middle-aged adult who has mastered or at least adjusted to sex, responds best to Adlerian-colored therapy. Still another type of patient is the person who has succeeded sexually, socially, and vocationally, but who develops symptoms or becomes unhappy in later life because he has not "found his soul." This type of patient responds best to therapy that incorporates Jungian teachings. The conflict between these schools is not based on erroneous treatment. It exists because the treatment is more specific to the age and adjustment of the patient than is generally recognized, and will be comparatively worthless when applied to the wrong person. Similarly in the field of religion, a poor rural patient would respond far better to a restrictive, non-permissive church, than he would to a big city church, where the little sins (smoking, picture shows, etc.) are not emphasized.

Since the whole problem of neurosis—its origin, effects, and treatment—is almost totally concerned with the "inner man," the "psyche," one may ask "Why should I go to a psychotherapist with my neurosis? Why not take it directly to God in prayer?"

A deep neurosis can be compared on the psychic level with a diseased appendix on a physical level. There are some religious groups who would say "Take your diseased appendix to God." There are many more, however, who would recommend

that the services of a competent doctor of medicine be engaged. So it is with neurosis. If a person is suffering from deeply disturbing emotional problems, which cannot be eliminated or relieved by pastoral help and admonition, then he may be said to have a deep neurosis, and help from a competent psychotherapist is indicated. Very often during the first consultation, I suggest that the patient discuss his problems with his minister. If the result is not satisfactory, then I advise him to return for psychotherapy.

We have seen that the tragic blocking of trust and the continued denial of it form the roots of some neuroses, since the need to trust is inexorably present in every human being. There is also present in every man a gnawing desire—no matter how deeply hidden—to be at peace with himself. This is an experience which no other human being can actually bring about. But the psychotherapist may contribute to the removal of obstacles which stand in the way. Obstacles, for example, such as moral and religious hypocrisy and self-deceit, which are the products of an uncomprising and "bad" conscience. Deceit and hypocrisy are not primary needs. They are rather defenses, like the bid for tyrannical power, or sexual lust.

The "instrument of cure" which the psychotherapist employs in his treatment is free association. The patient thinks aloud, his communications freed from conventional patterns of logical thought, and gradually the floodgates of long repressed emotions are opened. It is likely to be an arduous task, both for the patient and for the therapist. Truly, frankness does not come quickly or easily for the patient. Unfortunately, the ordinary minister ofttimes is the last person that a patient would reveal his "weakness" to.

The therapist provides the patient with an atmosphere of trust and confidence. An absolute confidential air and attitude are essential. Ideally, the therapist keeps his own feelings in abeyance, not allowing himself to become annoyed, nor to accept the bribery of flattery.

It is in this atmosphere of trust that the patient relieves the old fears and anxieties of his childhood, examining them again and again, and finding ultimately a more satisfactory and more constructive way of dissolving them.

If the therapist is pompous, critical, patronizing, or insincere he will lose his usefulness to the patient, just as surely as the same qualities will render the cleric ineffective. Only genuine respect and the feeling of acceptance will dispel the patient's extreme fears of being rejected, overpowered, or taken advantage of. Theoretically all of this should apply for the cleric as well as the psychotherapist. But truly it is not easy for either.

It is the function of psychotherapy, then, to remove deeply-rooted impediments, not recognizable or explainable on a conscious level, and to thereby pave the way for rational acceptance of self, of God, and of one's fellowman. But whether or not a patient achieves the goal of complete or approximate reconciliation and peace will not depend totally upon even the most earnest and sincere endeavors of the psychotherapist. It will depend a great deal upon the patient himself. The psychotherapist can accept human behavior as it really is and help to direct it into socially acceptable channels. But he does not try to change human nature. Even to the point of encouraging hypocrisy—no matter what the psychologic concept—the necessity of being accepted socially, or rather not being ostracized, is given precedence over complete or immediate personal gratifications.

That psychiatry and religion are closely related is undeniably true. And that psychiatry is still in disrepute among certain of the clergy is also unmistakably true. Yet it must be remembered that religion was not at first receptive to the young science of medicine. In fact, the early doctors of medicine were often in serious trouble with the churches, notably when they asked for the use of corpses for their scientific investigations and experiments. But concern for man's physical being has led the clergy to respect and to work with medicine. So it is that an increasing number of Christians in their Christian solicitude for man's spiritual welfare, will seek out the competent in the realm of psychotherapy. It is also true than an increasing number of psychotherapists will seek out and endeavor to understand and utilize religion in dealing with the spiritual needs of their patients. It has been my own personal experience to do just that. I am not at all hesitant to pray for help when I am baffled or blocked in my treatment of maladjusted or unhappy patients.

My personal evaluation of the relationship between psychiatry and religion is this: I believe that I can handle minor sins, and that the clergy can handle minor emotional problems. The danger point, which actually occurs, is reached when the psychiatrist decides to handle the major sins, or when the cleric takes it upon himself to tackle a major psychiatric problem. This happens usually when either the psychiatrist or the cleric wants to "play God" himself. The temptation to be God rather than to work for Him is great, and

many clerics (and psychiatrists) succumb to it. And the temptation to work for self rather than for the patient is the pitfall that the psychiatrist must be aware of and watch closely.

The question of which is minor and which is major both in the realm of sin and neurosis is answered by the therapeutic test, and will vary from one therapist to another. Similarly, clerics vary in their interest and ability to handle emotional problems. If both the psychotherapist and the cleric are willing and able to recognize their own deficiencies, neither will hesitate to refer to the other as soon as it is obvious that someone else can do a more effective job or do it quicker. In the final analysis, the honest cleric and the honest psychotherapist alike can point to even their most spectacular successes and say, with the French physician, "I treated him, God cured him."

PREVENTIVE PROGRAM FOR RETROLENTAL FIBROPLASIA IN ARKANSAS*

JOHAN W. ELIOT

Maternal and Child Health Division, Arkansas State Board of Health
and Pediatrics Department, University of Arkansas School of Medicine

The Maternal and Child Health Division of the Arkansas State Board of Health has recently made a somewhat specialized addition to the general consulting services in maternal and child health which it makes available to hospitals and clinics. This consists of consultation with medical and nursing staffs concerning the prevention of retrolental fibroplasia, that peculiar eye affliction of premature infants which has suddenly appeared within the last decade and assumed first place as a cause of blindness in children.

In recent years much evidence has accumulated that prolonged administration of a high concentration of oxygen,[1,2] and sudden withdrawal from oxygen,[3,4] are in some way very important factors in the etiology of retrolental fibroplasia. An increasing number of premature baby centers have successfully controlled this condition by limiting oxygen concentrations to 40 per cent or less. Experience in England and in this country, particularly in Arkansas, with care of premature infants in homes, without the use of oxygen, has been good. Arkansas has been less liberally supplied with hospitals and trained personnel than most other states, and so has only very recently begun to care for substantial numbers of premature infants in hospitals, with the use of oxygen. Perhaps we should be grateful for this circumstance, since there are probably less than twenty cases of retrolental fibroplasia which have developed in this state, which is relatively few compared to other, wealthier states. However, hospitals are now being equipped with modern incubators which can hold oxygen in concentrations well over 40 per cent, so that the need for spreading information on this subject has become urgent.

Methods and Equipment

The Maternal and Child Health Division has purchased and demonstrated an electrical and a chemical oxygen analyzer,† and has run some sample analyses, to give at least an idea of the oxygen concentrations found in incubators, in a number of hospitals throughout the state where this consultation service has been requested. Seven types of incubators were examined in these hospitals. Time was limited during visits to some hospitals, so that relatively few readings were made. The oxygen was allowed to run into the incubator for only one-half hour during some of the earlier readings, but it was soon found more accurate to run oxygen in for one hour or longer before taking a reading. If the ventilating holes in an incubator were closed, the concentration continued to increase for two hours or more, especially in the Isolettes.

Results

Table I presents the results of analyses of oxygen concentrations found in incubators in 24 hospitals in various parts of Arkansas. The values in Table I have been arranged so that all the values in one horizontal line pertain to a single incubator and the individual incubators have been listed roughly in the order of their ability to retain oxygen. Some of the observed differences between incubators of the same type may be due to differences in oxygen flow-meters, which may be

* A University of Arkansas School of Medicine Research Paper.

† The Maternal and Child Health Division solicited bids on these two types of analyzer and on the basis of bids received, purchased a Mira Oxygen Analyzer (electrical type), manufactured by Oxygen Equipment and Service Co., 8335 South Halstead Street, Chicago, Illinois, and an OEM Oxygen Analyzer (chemical type), manufactured by the Oxygen Equipment Manufacturing Corp., East Norwalk, Conn. The electrical analyzer is easier to operate, but cost four times as much as the chemical analyzer and turned out to use a specially made battery, which was difficult to replace.

TABLE I

Oxygen Concentrations in Incubators in 24 Arkansas Hospitals

Type of Incubator	Oxygen Flow in Liters per Minute							
	½	1	2	3	4	5	6	10
	Per cent							
Gordon-Armstrong			27		30		34	
(Standard X-4)			27	30	35		38	
Vents open			28		30		37	
		25	28		38		47	
			29		37		47	
			32					
		29	32				36	
			33		38		40	
			33		40			
			34		35			
			35		36			
			36		40			
		37			38		40	
			37	38	41		48	
			37	45		55		
			38	42	53		60	
		40	43	45	46		49	
		48	49	52	55		57	
		48	56					
	40	50	56					
Vents closed			33		59		67	
			33		40		42	
			38					
			39		42		45	
			40		45		54	
			43		41			
			43		50			
			45		52			
		47	53					
			55		67		76	
		45	57					
		48	58					
Gordon-Armstrong (Explosion-proof) Vents open			40			47		
Isolette		29	33		42		46	
Vents open	28	31	34		38		40	
		30	35		53		55	
	29							
			35				55	60
		31	36		42		48	
			39	46	50			
			40					
		32	40					
			41	42	46			
		33	41		47		53	
			41	42	50			
			44	47	59			
		33	46		65		76	
Isolette		38	48					
Vents closed			51				90	
			59		76			
			71		84			
Baby Haven								
Top vents open								
Bottom vents open				30		35		
Bottom vents closed				37		45		
Aloe Infant Incubator		40			47			
Arkansas State Board of		40	55					
Health Incubator		40		53			60	
Infantair Incubator		30		40				
Electric Hotpack Co. Incubator							25	

notoriously inaccurate. Table II shows the differing oxygen concentrations found with one incubator attached to different oxygen flow-meters of the same brand, all using the same oxygen source.

Many flow-meters are incapable of registering less than 2 liters per minute flow. Only a few could register 1 liter per minute or less, such as the Linde Oxygen Therapy Regulator and Flowmeter Type R-501, Linde Oxygen Therapy Flowmeter Type L-14, or the National Cylinder Gas Co. Liter Flowmeter Model No. 211, each of which was seen working well in one or more hospitals. Reference to Table I makes it clear that it is necessary to use flow-meters capable of registering 1 liter per minute flow, and preferably ½ liter per minute flow, in order to secure oxygen concentrations of 30 to 40 per cent.

TABLE II

Oxygen Concentrations Produced by Different Oxygen Flow-Meters

(Gordon-Armstrong incubator; vents open; all Victor Flow-meters; all readings at 4 liters per minute.)

Flow-meter Number		
No. 1—49%	No. 4—47%	No. 7—49%
No. 2—51%	No. 5—52%	No. 8—48%
No. 3—43%	No. 6—45%	No. 9—46%

It is quite evident from Table I that any one type of incubator can vary greatly in the concentrations of oxygen it will hold at various rates of oxygen flow. It was noted that the Isolette generally holds somewhat higher concentrations of oxygen than other types of incubators, and this is certainly true when the air vents are closed. The Gordon-Armstrong incubator generally held concentrations under 40 per cent at 2 liters per minute, with the vents open, higher with the vents closed. However, there were a few startlingly high figures even with vents open, enough to warn any hospital that oxygen concentrations cannot be guessed at.

The state-owned incubators were hand-made during World War II, when other incubators were unobtainable. It was somewhat of a surprise to

find how tightly they retained oxygen. At least one baby is known to have become blind in a state-owned incubator, in which he received oxygen therapy in a hospital. State-owned incubators are still being used in some hospitals, but are being withdrawn from hospitals as rapidly as they can be replaced by standard commercially-made incubators, and will be devoted exclusively to use in homes, for which they were designed.

The Vapojet attachment sold with the Isolette has holes in its tube which can be opened or closed in three stages by adjusting a movable collar on the tube. Air in varying proportions is thereby sucked in with the oxygen stream. This feature provides a more positive and rapid, though not necessarily more exact control over oxygen concentration than the gradual build-up of concentration which occurs when oxygen alone is run into the incubator. Table III shows some concentrations found in 5 different Isolettes. It will be noted that with the Vapojet running, the oxygen concentration seemed to be far more potently influenced by changing the collar setting of the Vapojet to suck in more or less air into the oxygen stream, than by closing the ventilating holes of the Isolette. The second feature which will be noted is that the values obtained for collar settings conform substantially, but not completely to the ranges printed on the Vapojet bottle, which are as follows: Setting 1—35 to 38 per cent; Setting 2—40 to 45 per cent; Setting 3—48 to 53 per cent. It is evident that the Vapojet should be used only with the tube holes open, i. e., with the collar at Setting 1, if the oxygen concentration is to be kept under 40 per cent.

TABLE III

Oxygen Concentrations in Isolette with Vapojet Running

Incubator	Vapojet Collar Setting	Lower Vents of Isolette	Oxygen Flow in Liters per Minute 4	5
A	1	Open	37%	
	1	Closed	40%	
	3	Open	68%	
	3	Closed	70%	
B	1	Open	38%	39%
	2	Open	51%	46%
	3	Open	62%	67%
C	1	Open	36%	38%
	2	Open	43%	44%
	3	Open	55%	58%
D	1	Open	40%	41%
	2	Open	46%	47%
	3	Open	71%	71%
E	1	Open	33%	33%
	2	Open	37%	39%
	3	Open	46%	47%

There are various known sources of variation between oxygen concentrations in different incubators of the same type, and in the same incubator from time to time, besides variations in flow-meters. The fullness of the oxygen tank somehow seems to exert an influence, even though the flow be maintained at a constant level on the flow-meter. Table IV shows some sets of readings taken on several incubators, with the only known variable between the high and low readings being the fullness of the oxygen tank. Others have reported that the temperature of the oxygen tank, and oxygen lines where they pass through building walls, influences the oxygen concentrations in incubators.

TABLE IV

Variations in Oxygen Concentration with Nearly Full and Nearly Empty Oxygen Tanks

Incubator	Oxygen Tank	Oxygen Flow in Liters per Minute 1	2	3	4	5	6
		Per cent					
A	Nearly full		46				
	Nearly empty		37				
B	Nearly full		38	42	53		
	Nearly empty		30	33	45		
C	Nearly full	48			50		57
	Nearly empty	42			45		51
D	Nearly full				50		
	Nearly empty				44		

An obvious source of variation in oxygen concentration in incubators is any oxygen leak along the line between the flow-meter and the interior of the incubator, or in the incubator itself. Rubber tubing should be checked for leaks and kinking, and metal joints should be tested by putting a little water around them and looking for bubbles. Table V shows the results of one hand hole left open enough to admit a wrist, inadvertently not discovered until an entire set of readings on an Isolette had been completed.

TABLE V

Influence of Open Hand Hole in Isolette on Oxygen Concentrations

Vapojet Collar Setting	Hand-hole	Oxygen Flow in Liters per Minute 1	2	3	4	5	6
		Per cent					
1	Open				37	38	
	Closed				40	41	
2	Open				41	42	
	Closed				46	47	
3	Open				49	53	
	Closed				71	71	

In addition to the incubators tested, two other devices in which babies may receive oxygen were tested. The Rockette, a resuscitating device which rocks a baby back and forth in the hopes of moving its diaphragm and of promoting circulation through the heart valves, was tested with oxygen running in at 1 liter per minute. The oxygen concentration at the end of one hour was 100 per cent. This device is very tightly constructed, with no ventilating holes. It obviously needs to be redesigned, to prevent such high oxygen concentrations, and to prevent the baby from suffocating, should the oxygen supply fail.

The Bloxsom Air-Lock, a device which is intended to resuscitate a baby by subjecting it to alternating pressures of 1 and 3 atmospheres, is designed to operate at oxygen concentrations of 60 per cent and up, with no provision for lower concentrations. It has a special flow-meter calibrated directly in oxygen percentage. When this was set at 60 per cent, the Air-Lock contained 69 per cent; with the setting at 80 per cent, the Air-Lock concentration was 84 per cent. Aside from questions as to the logic or efficacy of the Air-Lock, it would seem that the device has no place in premature infant care unless it can be so modified as to deliver safe concentrations of oxygen.

Recommendations to Hospitals

Hospitals have been encouraged to purchase an oxygen analyzer, so that oxygen administration may be ordered in terms of concentration, rather than liters per minute. The regulation of oxygen concentration will require knowledge and use of the oxygen analyzer by the nursing or maintenance staff on a round-the-clock basis. Two large hospitals already had such analyzers for use with other equipment, which now will also be used to measure the oxygen concentration in the incubators.

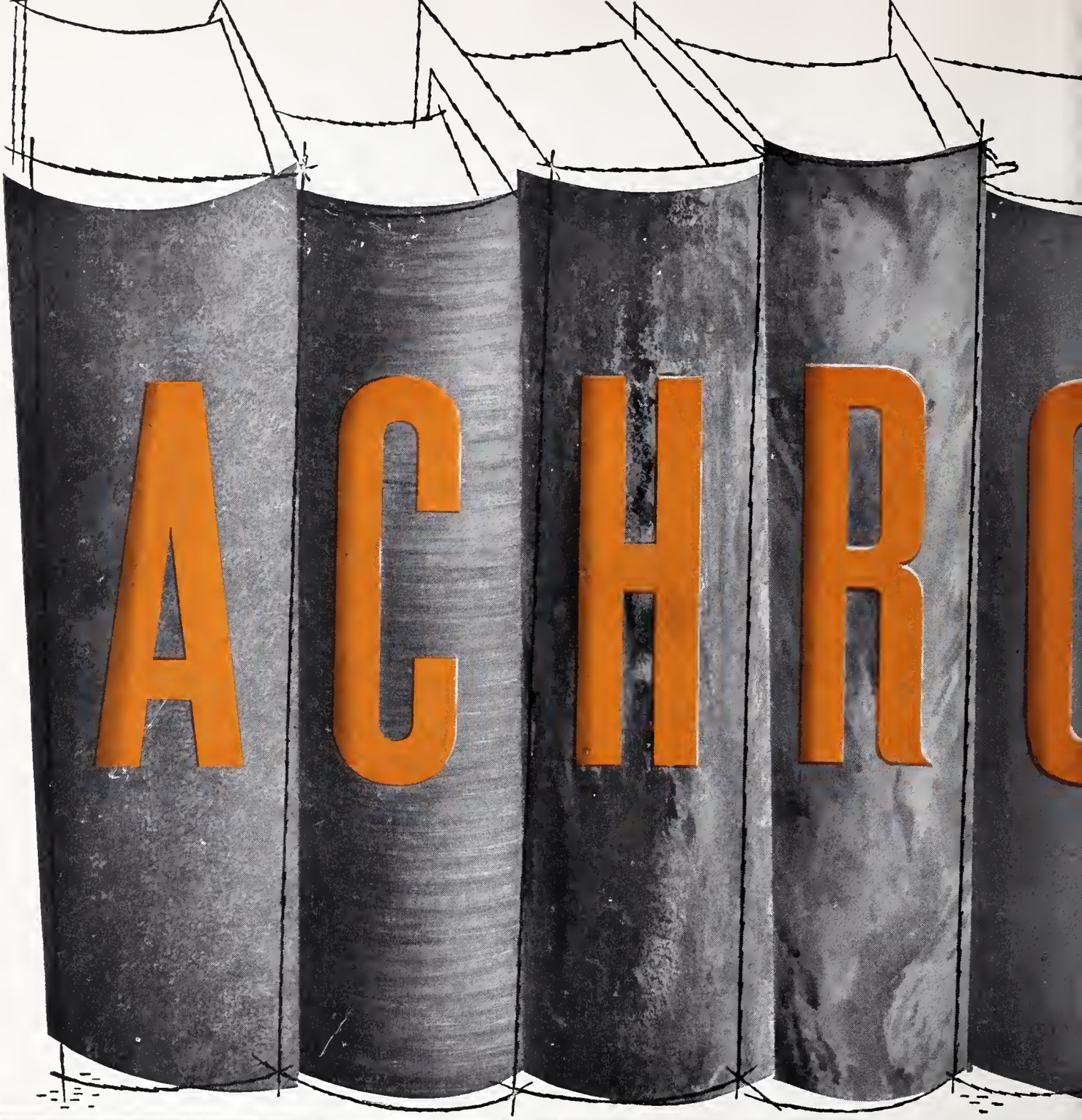
In addition to establishing means for controlling oxygen concentrations in incubators, hospitals have been urged to establish routine observation of the ocular fundi of premature infants, starting between two and four weeks of age. Szewczyk and others have established the fact that early stages of retrolental fibroplasia, consisting of tortuosity and dilatation of retinal vessels, small hemorrhages and vitreous opacities, will tend to regress to normal if a baby is put back into oxygen.[3,4] The oxygen concentration is then very gradually lowered and no further trouble is usually encountered.

In order to establish such observation and treatment, the hospital, nursing staff, and physicians will need to establish definite routines, and explain and interpret them to parents. It is not at all sufficient to examine a premature infant's eyegrounds at the time of hospital discharge, and declare the baby out of danger. The baby is really just entering the period of acute danger at this time. All too often a baby has been brought back for a routine checkup a month to six weeks later, only to find that retrolental fibroplasia has developed in severe degree in the interval since discharge. The physician and parents, perhaps with cooperation of the hospital and public health nurse, need to set up a planned schedule of weekly visits after hospital discharge, which nothing must be permitted to interrupt, until two to three months of age. Parents of a baby who has received considerable oxygen will need to be warned of the possible necessity of bringing the baby back into the hospital, incubator, and oxygen at a time when he will appear to them to be in perfect health and in no visible need of therapy.

Nursing staffs should develop a routine for instillation of drops into the premature infant's eyes to dilate the pupils, an hour before the physician arrives to inspect the fundi. The University Hospital in Little Rock has been using a mixture of Homatropine 2 per cent and Neosynephrine 5 per cent, in a 1:10,000 aqueous Zephiran chloride solution. One drop is put in each eye, and five minutes later another drop is put in each eye. Some physicians may find an infant eyelid retractor useful (such as the Bedrossian Infant Eye Specula, available through George P. Pilling & Son Co., 3451 Walnut Street, Philadelphia).

It is hoped that the establishment of control over oxygen concentrations, plus routines for periodic examination of the eyegrounds of premature infants, will keep the incidence of retrolental fibroplasia low in Arkansas, while permitting the safe use of new and improved incubators and oxygen apparatus. The measures discussed in this paper are mundane, simple and repetitive, like so much of preventive medicine, but neglect may mean a lifetime of blindness. Quite aside from the human values involved, it is worthwhile remembering that it costs the State of Arkansas approximately $10,000 more to educate a blind child than a normal child.

Physicians are urged to report any child who develops retrolental fibroplasia to the Register of Partially Seeing Children, Supervisor of Special Education, State Department of Education, Little Rock, so that the child may receive all of the educational opportunities available through this department and through the School for the Blind.



Medical history is being written today

Lederle

• REG. U.S. PAT. OFF.

Hydrochloride
Tetracycline HCl *Lederle*

The introduction and rapid widespread adoption of ACHROMYCIN has opened a new chapter in the history of broad-spectrum antibiotics.

ACHROMYCIN fulfills the requirements of the ideal antibiotic in virtually every respect . . . wide-range antimicrobial activity, *in vivo* stability, tissue penetration, minimal toxicity.

ACHROMYCIN is truly a broad-spectrum weapon, effective against Gram-positive and Gram-negative bacteria, as well as certain mixed infections.

ACHROMYCIN is more stable and produces fewer side effects than certain other broad-spectrum antibiotics.

ACHROMYCIN provides prompt diffusion in body tissues and fluids.

ACHROMYCIN is destined to play a major role among the great therapeutic agents.

LEDERLE LABORATORIES DIVISION AMERICAN Cyanamid COMPANY PEARL RIVER, NEW YORK

Summary

Recent studies have shown a definite connection between development of retrolental fibroplasia, and administration of high concentrations of oxygen to premature infants. Therefore the Maternal and Child Health Division of the Arkansas State Board of Health has tested the oxygen concentrations in incubators in 24 small and large hospitals in Arkansas, and demonstrated the use of two types of oxygen analyzer. Considerable variation between incubators of the same type was found, sufficient to demonstrate the need for actual measurement of oxygen concentrations, rather than estimation of oxygen levels based on performance of incubators and oxygen flowmeters in other places. The following recommendations to hospitals have been made: (1) Obtain an oxygen analyzer; (2) Train personnel to use the analyzer, on all hospital shifts; (3) Physicians' orders specify oxygen therapy in terms of percentage, rather than liters per minute; (4) Install oxygen flow-meters capable of measuring 1 liter, or preferably 1/2 liter per minute, for use with incubators; (5) Establish a routine procedure for examination of the ocular fundi of small premature infants, during and after their hospital stay, to detect early stages of retrolental fibroplasia; (6) Return infants showing such early stages to oxygen in the incubator; (7) Report infants with permanent retrolental fibroplasia to the Register of Partially Seeing Children, Supervisor of Special Education, State Department of Education, so that they and their parents may receive educational help at an early age.

BIBLIOGRAPHY

1. Patz, A., Hoeck, L. E. and DeLaCruz, E. Studies on the effect of high oxygen administration in retrolental fibroplasia. Am. J. Ophth., 35:1248, 1952.
2. Lanman, J. T., Guy, L. P. and Dancis, J. Retrolental fibroplasia and oxygen therapy. J.A.M.A., 155:223, 1954.
3. Szewczyk, T. S. Retrolental fibroplasia; etiology and prophylaxis. Am. J. Ophth., 34:1649, 1951; 35:301, 1952.
4. Jefferson, E. Retrolental fibroplasia. Arch. Dis. Childh., 27:329, 1952.

COMING ATTRACTIONS

CLINICAL MEETING

American Medical Association

Dinner Key Auditorium, Miami, Florida
November 30 - December 3, 1954

The Interim Session of the American College of Chest Physicians will be held in Miami Beach, Florida, at the Delano Hotel, November 28-29, 1954.

The American Medical Association, in conjunction with United Air Lines, has arranged an attractive post-convention tour to Europe. Seven countries will be visited: France, England, Italy, Holland, Belgium, Germany, and Switzerland. Physicians and their wives can go to Europe following the annual A.M.A. Convention in Atlantic City, June 6-10.

The European medical tour party will leave New York International Airport aboard special deluxe chartered airliners on Sunday, June 12. They will arrive in Paris late Monday morning, June 13.

Arrangements are being made for medical meetings in Paris, Rome, Lucerne, and London.

The return trip will be on Saturday, July 9, arriving in New York on the afternoon of July 10. Complete information and reservation blanks can be obtained by writing A.M.A. Post-Convention Tour, care of United Air Lines, 5959 South Cicero Avenue, Chicago 38, Ill.

State Doctors Invited To Jamaica Medical Meeting

Members of our State Society attending the A.M.A. Interim meeting in Miami are invited to a post-convention meeting of the British Medical Association, Jamaica Branch, at Kingston, capital city of the Island, on Saturday, December 4, at 10 a. m.

Further details will be available at Information Desks at the Miami meeting, from American Express Company and local travel agents, or from the Miami office of the Jamaica Tourist Board, 1631 duPont Building.

ARKANSAS MEDICAL SOCIETY

Hot Springs — May 30 - June 1, 1955

COMMITTEES OF THE ARKANSAS MEDICAL SOCIETY

(Supplementary to list published in August 1954 Journal)

COMMITTEE ON PUBLIC HEALTH

Term expires April,

Sub-Committee on Tuberculosis

Jerome S. Levy, 1425 W. 7th, Little Rock, Chairman 1957
A. B. Dickey, State Sanatorium 1955
Duane Brothers, Ozark 1956
Harley C. Darnall, 700 S. 26th, Fort Smith 1957
Harvey Shipp, Donaghey Bldg., Little Rock 1955
Sanford Monroe, 1409 Cherry, Pine Bluff 1956

Sub-Committee on Mental Health

E. H. Crawfis, Arkansas State Hospital, Little Rock, Chairman 1957
Wm. G. Reese, Medical School, Little Rock 1956
Robert F. Hyatt, Monticello 1955

Sub-Committee on Liaison with the State Board of Health

Tasker N. Rodman, Leachville, Chairman 1955
W. J. Rhinehart, Donaghey Bldg., Little Rock 1957
T. L. Adair, Bald Knob 1956

Polio Advisory Sub-Committee

E. H. Crawley, 1417 West 6th, Little Rock, Chairman 1957
James T. Rhyne, 1125 Cherry, Pine Bluff 1956
W. H. Pruitt, Camden 1957
Katharine Dodd, Medical School, Little Rock 1955
John Hundley, 412 Cross, Little Rock 1955

COMMITTEE ON MEDICAL EDUCATION

Sub-Committee on Postgraduate Education

James M. Kolb, Clarksville, Chairman 1957
Paul Sizemore, Magnolia 1956
G. K. Patton, 1309 East Main, Van Buren 1955

Committee on the A.M.E.F.

W. R. Brooksher, 100 N. 16th Street, Fort Smith

COMMITTEE ON HOSPITALS

Sub-Committee on Liaison with Blue Cross - Blue Shield

Sam Jameson, 412 N. Wash., El Dorado, Chairman 1957
Gerald Teasley, Box 778, Texarkana 1956
Bill Dave Stewart, 5901 "A" St., Little Rock 1955
A. S. Koenig, First Nat'l Bank Bldg., Fort Smith 1957
Howard S. Stern, 1315 Linden St., Pine Bluff 1955

COMMITTEE ON PUBLIC RELATIONS

Sub-Committee on Liaison with the Nursing Profession

Hoyt Choate, 1120 Marshall, Little Rock, Chairman ..... Permanent
Robert F. Hyatt, Monticello ..... Permanent
Woodbridge Morris, Baptist Med. Arts Bldg., Little Rock ..... Permanent

Sub-Committee on Veterans Affairs

Elvin Shuffield, Donaghey Bldg., Little Rock, Chairman 1957
L. E. Drewery, Camden 1956
L. A. Whittaker, 321 North 13th St., Fort Smith 1955

OBITUARY

WILLIAM HENRY HORN, 83, pioneer physician of Columbia County, died September 14 after a brief illness.

Dr. Horn, who had been practicing medicine for more than 63 years, having started in his teens, founded the Magnolia Sanatorium, the first hospital in this city.

He was the oldest practicing physician in Columbia County, having been active until his final illness.

A graduate of the University of Tennessee's school of medicine at Memphis, Dr. Horn served on the faculty of the Gate City Medical College at Texarkana, Tex., in 1906 and 1907.

He was a member of the Columbia County Medical Society, the Arkansas Medical Society, the Southern Medical Association, and the American Medical Association. He was a 32d degree Mason in the lodge at Taylor and a Shriner, member of the Scimitar Temple of Little Rock.

Funeral services were held at the Forest Grove Baptist Church, west of Taylor. Burial followed in the Forest Grove cemetery.

He is survived by his widow, Mrs. Alpha Hollingsworth Horn, and four children.

APPOINTED TO U. OF A. FACULTY

Terry Rodgers, formerly of New York, has been appointed associate clinical professor of psychiatry of the University of Arkansas School of Medicine and as a consultant to the Veterans Administration Hospital, North Little Rock, and to the Arkansas State Hospital, Little Rock.

Dr. Rodgers received his M.D. from the U. of A. in 1940. After completing internship at University Hospital in 1941 he served in the Navy Medical Corps until 1946. He was engaged in private practice of psychiatry and psychoanalysis in New York from 1948 to 1954.

Dr. Rodgers has published various specialized articles in his particular field, including: "Marijuana and Aggressive Crime," "Authority in the Treatment of Delinquents," and "A Dynamic Study of the So-Called Psychopathic Personality."

Dr. Rodgers will reside at 1820 N. Jackson, Little Rock, with his wife, the former Mary Katheryn Maxey of Little Rock, and their three daughters.

Arkansas TRAVELING

And Clipping Bits Here and There

Dr. H. M. Marvin, President, Connecticut State Medical Society—"People consult physicians usually because they are sick in body or troubled in mind and spirit. For the most part, they come in good faith, confident of receiving help. To deny them the comfort of a truthful and understanding explanation, whenever this is possible, is to fail in one of the simplest and most important duties of a privileged and honored profession."

State A.M.E.F. Chairmen to Meet

American Medical Education Foundation state chairmen will kick off the 1955 fund-raising campaign with a meeting Sunday, January 23, at the Sheraton Hotel, Chicago. This fourth annual meeting will launch officially the medical profession's concerted efforts to raise voluntary funds for the nation's medical schools. Primary purpose of the one-day session is to exchange ideas on local promotions. Representatives from every state, as well as regional auxiliary chairmen, will be on hand for the meeting.—AMA Newsletter.

Dr. F. J. L. Blasingame, Trustee, American Medical Association and President, Texas Medical Association—"In matters scientific, all is well, and men and women in medicine are for the most part highly respected. But in matters pertaining to the socio-economic problems of medicine all is not well. Leadership in matters of health is being challenged constantly. Naturally, in a competitive society as we have in America, other groups, especially those with high pressure leanings, will absorb this leadership if the medical profession is not vigilant of its responsibilities every day of the year."

Did you know that Blue Shield helped pay for 1,189 babies in Arkansas during the first six months of this year? That's almost 200 babies per month. On obstetrical cases **only,** Blue Shield has paid the doctors and members $58,621.25 through June 30, 1954.

Blue Cross took an active part in these babies' hospital bills by paying to the hospitals and its members $863,110.31 during the same period of time. The combined average paid by Blue Cross-Blue Shield for each baby was $112.90 in the state of Arkansas for this six month period.—Blue Cross Scribe.

Keep Health Insurance Voluntary

On the basis of a great deal of additional information given to us by the insurance industry, we are compelled to reverse our past position favoring the Eisenhower administration's health reinsurance program.

During the past few years several insurance companies have entered the field of catastrophe insurance and now supply policies that cover extraordinary medical expenses at a reasonable cost which the average citizen can pay. Mr. E. A. McCord, president of the Illinois Mutual Casualty Company, has pointed out that his company, for instance, provides catastrophe insurance to cover expenses up to $10,000. It is possible for a man and wife in their 40s with three or more children to get coverage for medical expenses up to $5,000 for as little as $93 a year or $8 a month. Of course the first $500 of such a catastrophic expense is deductible and must be paid by the insured person.

Mr. McCord also pointed out that this type of catastrophe insurance is now being written by the insurance industry largely without any private reinsurance program. The capacity of the industry as a whole to provide this kind of insurance is great and there is no need for the proposed $25,000,000 government fund for this purpose.

Certainly there is a widespread misconception in the United States, which we ourselves have shared, that the insurance industry has been either unwilling or unable to provide reasonably priced catastrophe insurance. It has undoubtedly been spread by the strenuous and effective efforts of those favoring a government-controlled health program. The insurance industry's own failure extensively to dramatize its contributions and to capitalize on them with the public is also responsible.

As we have stated repeatedly in the past, it is a sound principle of government that government should never invade a social welfare field in which private or semi-public agencies are able and willing to provide what is needed. It seems clear that the insurance industry has the capacity and is now showing the willingness to handle this special and long neglected field of catastrophe health insurance.

The best way to prevent socialized medicine or socialized insurance is to eliminate, through private effort, any need or demand for them and to do so before government gets started in the field.

The Eisenhower administration can hardly claim a need for government action if the insurance industry has already taken action without government help. And surely if the insurance industry is successful in selling its catastrophe insurance plans on a voluntary basis to the majority of Americans, there will no longer be any reasonable demand for government action. We hope that happens.—The Indianapolis Star, Sept. 25, 1954.

American College of Radiology Contributes

Mr. William C. Stronach, executive secretary of the American College of Radiology, recently forwarded a check in the amount of $2,000 representing a gift to the Foundation from the ACR. Since the inception of the Foundation in 1951, the American College of Radiology has supported the AMEF program and has received two Awards of Merit for outstanding contributions.

Dr. Harlan English, A.M.A. Delegate from Danville, Illinois—"Some professional people know the price of everything and the value of nothing. Being exposed to the **'gravy of grateful hearts'** might change their views on public relations, which are the sum total of our private patient relationships and cannot be measured by surveys or bought with dollars."

Someway, somehow, Dr. Harold Camp, secretary of the Illinois society, came up with this quote from Dr. Robert Boal of Peoria, which was published in 1882: "The amenities of professional intercourse, and the obligations of medical men toward each other and the public, were perhaps better observed in 1850 than now. Then the doctor, next to the minister, was the trusted friend and counselor of every family to whom he ministered. He shared their joys, soothed their sorrows, and every passing year added to and cemented the attachment and affection between them. Now the doctor is regarded more in the light of a tradesman or mechanic, and is employed from the same consideration that a grocer, tailor or shoemaker is. The strong ties of gratitude and affection have almost ceased to exist. Relationship is now placed upon a mere commercial basis, and for this the profession is more to blame than the public."

★ Editorial ★

After the many defeats, and the two victories, that the AMA and every physician suffered at the hands of the Eisenhower Administration during the last two years, one wonders at the apathy, not only in the individual physician, but also in some of our officials.

The AMA won two battles which may be turned against us yet. First win came in keeping the physicians off the "Social Security" rolls, thanks to a kindly tip-off from one of our Congressmen. That victory was, by far, the greatest, and sparked by our own President Brooksher and Executive Secretary Paul Schaefer who drew hundreds of telegrams of protest to Washington from physicians and AMA officials in every state.

The second win came in defeating the Reinsurance Program, about the most useless piece of legislation that had the Eisenhower backing. It is strange, indeed, that the President, as late as August 23 of this year, should be still insisting on such legislation.

Probably the worst of our defeats came when Section 106 of the Social Security code was adopted over the effort of a few of our physician leaders like Francis J. L. Blasingame, of Wharton, Texas, who saw its insidious features. This particular battle was lost because not enough of our leaders saw through the camouflage, and the opposition was of the "too little and too late" variety.

The Washington Office has warned us that the President is cooking up a stew to force the Reinsurance Program down our throats, and we might be ready. We might also organize a repeal of Section 106 of the SS Act, so that the Drs. can be taken off Mrs. Hobby's hook, though repeal will mean that every member of the House of Congress will have to be contacted by some physician in his home town. This work should be in the process of organization now. It should be done while our Representatives are at home feeling out the sentiment. The Washington office of the AMA can be our "listening post," but the real influence is from some private physician at home.

A united front by physicians on legislators is a powerful force. One doesn't have to be in Washington, or even out of his office, to talk to his Congressman, and reflect to him the thinking of the sounder element of our country.

There should be plans among our Medical leaders **now** to repeal Section 106, to promote the

Bricker amendment, to curb the "give away" program that Eisenhower adopted from the Truman Administration, and to aid other professional groups, engineers, etc. in getting out from the onus of the Social Security tax and dole. The engineers realized belatedly that they forgot to fight for liberty. Perhaps some spark of hope can be raised for them if physicians keep alert, organize for strength and carry the battle by attack instead of being defeated by no defense. The fight for liberty was not made alone at Bunker Hill. It is being made today.

Under the new Vocational Rehabilitation Act federal funds have been allocated to states which take into account a state's per capita income as well as its population. The Arkansas grant is as follows:

Maximum U. S. share	State share
$410,124	$265,659

For the current fiscal year a total of $24.5 million is available as U. S. aid in rehabilitation work, plus $1.5 million for extension and improvement of projects and $1 million to be allocated (**at the discretion of the Secretary of HEW**) for special projects. The U. S. pays 75 per cent of costs for extending and improving rehabilitation work, and two-thirds of the cost of special projects.

Ed. note (boldface ours): The "Federals" never fail to try to keep the power concentrated into some bureaucrat. This fund probably cost American taxpayers twice its amount.

We occasionally hear the remark that a physician should not be appointed to the board of trustees of a public hospital, that such functions should remain in lay hands alone. Somehow we have never been able to see why, nor have we ever understood why being on the staff of a hospital has made us unfit to serve on its Board of Directors or trustees.

A little leafing on this subject has brought to light the fact that a great many hospitals have put physicians on their directing boards. Not only in our immediate vicinity, but in many of the metropolitan areas. Harper Hospital in Detroit, for example. Some of them have stipulated in their charters that at least one physician should be on the board. Within the last few weeks a physician has been appointed to the board of governors of the Paragould Hospital, and he was promptly elected to an office. Power to him. We believe that a physician can contribute quite as much as any other man to such a group, and we consider such a step as being a wise one.

In the current edition of the "Techni-caller," the official publication of the Arkansas Society of Medical Technologists, which is now being addressed for mailing to the High Schools of this State, is an announcement to the Seniors of a competition whereby that Senior student submitting the best article titled "Why I Want to Be a Medical Technologist" will win a certificate for the sum of one hundred dollars to be used in defraying expenses incurred during an internship in an approved school of medical technology in this State.

The article is to be submitted by March 15, next, to the Editor of the "Techni-caller," St. Vincent Infirmary, Little Rock, Arkansas, and will be judged by specified officers of this society. The award will be presented by its president at the following annual meeting of the society.

If further information is desired, write to Walter T. Case, 573 Broad Street, Batesville, Arkansas.

Note: Here is something the medical profession needs to applaud.

PUBLIC RELATIONS

Physician
Patient
Personal

The following is a recent clipping from the local newspaper of Texarkana, Arkansas-Texas:

PRE-NATAL CARE PROGRAM OFFERED MOTHERS-TO-BE. Over 100 expectant mothers who cannot afford pre-natal care are availing themselves of a new program at St. Michael's Hospital which offers a weekly pre-natal clinic free of cost and provides hospitalization at a minimum charge.

Sister Mary Emerita said Friday that the program has been operating since the first of the year. The Clinic is held each Thursday at 9 A.M. at the hospital.

Called the Miller and Bowie Pre-Natal and Maternal Clinic, the program was organized by a group of local physicians in cooperation with the Sisters of Charity of the Incarnate Word, who operate St. Michael's Hospital.

The physicians and the Sisters work on a rotating schedule in volunteering their service to the clinic. Representatives of the Miller and Bowie County Health units are also in attendance at the clinics.

In cases requiring hospitalization, the charges for hospitalization will be below the actual cost for such care.

Sister Emerita said, "In the event the patient has no means for paying the charges, she will be admitted without charge for delivery."

"This program is a long step forward in carrying out the responsibility of the profession to the public, which it has always felt and attempted to uphold," Sister Emerita said.

Wm. B. Harrell, Chief of O.B. and Gyn., St. Michael's Hospital; all of the physicians of the Miller and Bowie County Medical Societies; and the Sisters of Charity of the Incarnate Word, who operate the hospital, are to be sincerely commended for their excellent example of public relations in action.

TUBERCULOSIS ABSTRACTS

A Review for Physicians

ISSUED MONTHLY BY THE NATIONAL TUBERCULOSIS ASSOCIATION

ISOLATING THE RECALCITRANTS

ROBERTS DAVIES, M. D., NTA Bulletin, June, 1954

During the past five years Firland Sanatorium in Seattle, Washington, has had an unusual and perhaps unique experience in treating tuberculosis in a large number of persons comprising one of the most unfortunate segments of society—vagrants and chronic alcoholics. This discussion is an attempt to share the experience with others who may face similar problems. It is by no means a blue print for action, since the staff of Firland Sanatorium does not believe that the best answer to any of the problems encountered is known at this time.

Adequate Beds Available

The situation in the state of Washington has been unusual in that since 1947 in our city, county, and state we have had more beds for the treatment of tuberculosis than have been needed. In the second place, and perhaps largely because there has been an adequate number of beds, the state and local health officers have been zealous in their attempts to isolate every individual known to have infectious tuberculosis and to find the unknowns as rapidly as possible. A city-wide mass X-ray survey in 1948 included the Skid Row area and for several years the Seattle-King County Health Department has X-rayed each new admission to the King County Jail and to the Alcoholic Rehabilitation Center. This survey has recently been extended to the Seattle City Jail.

Locked Ward Necessary

The policy of enforced isolation has necessitated a locked ward which is a part of the hospital and to which patients are admitted by order of local health officers from anywhere in the state. An occasional patient is admitted on parole from one of the state penal institutions or mental hospitals for treatment of a tuberculosis lesion that cannot be treated in the referring institution. But the great majority of admissions to the locked ward are unemployed or very irregularly employed chronic alcoholics from the metropolitan area.

The first detention facility was a large open ward, but numerous difficulties, ranging from fights between patients to arson and mass escape, have taught that such an arrangement was impractical. There is now a 52-bed ward consisting entirely of single rooms, except for two double rooms in the small and separate area for women patients. There are double sets of locked doors to the outside and windows are covered by heavy screens. All of the rooms can be locked individually. Almost all the rooms have furniture like that in the other rooms in the hospital. A few have only concrete blocks on which a mattress can be placed and have doors which are much heavier than the others. These rooms are reserved for patients who present an unusual risk of suicide, assault, or destruction of property. The whole ward is painted in light colors and is physically as attractive as any other ward in the hospital.

Recreation Facilities Furnished

Except for the maximum security rooms, patients' doors are locked only at night. Visiting between patients is permitted but congregation of

large groups is discouraged. Reading material, radios, and television sets are permitted as on any other ward. Occupational therapy which does not require dangerous instruments, such as knives, is encouraged. The facilities of the Departments of Social Service, Rehabilitation, and Education are furnished as on any other ward, and the services of chaplains and psychiatrists are available. The decreased emphasis on bed rest has created a need for more recreational facilities and a recreation room is now being provided. Visitors from outside the hospital are permitted, but only at one end of the ward, where the visitor is separated from the patient by a heavy fine mesh screen. Patients from the other wards are not permitted to visit patients in the locked ward except in an emergency.

The patients in the locked ward are not permitted to have money or valuables. These are kept for them and they may make purchases by written order on their accounts in the hospital business office. Their mail is opened and read and any packages are opened and inspected in order to prevent narcotics or other undesirable material reaching the patients.

Punishment Not the Purpose

Although there is forced confinement, punishment is no part of the purpose of this program and that fact is emphasized to both patients and employees. The locked ward has only two purposes. These are closely related. The first is to isolate from the public those few patients with infectious tuberculosis who will not stay in a tuberculosis hospital unless they are locked in and who cannot or will not isolate themselves outside the hospital. The second purpose is to protect the other patients of the hospital from disturbance, chiefly from drunkenness, on the part of those few patients who cannot observe the usual standards of conduct.

The average patient who is admitted to the locked ward stays about two weeks and is then transferred to an open ward of the hospital. If he leaves the hospital without permission or becomes disturbing to others, usually because of drinking, he is readmitted to the locked ward for perhaps a month.

On the third admission he will probably stay three months. On the fourth admission he may stay six months or until he is eligible for discharge from the hospital.

The great majority of patients who are admitted to the locked ward are not very troublesome. As a result of the aggressive program of tuberculosis control, from 200 to 300 chronic alcoholic patients are constantly in the hospital but the census on the locked ward is usually about 30.

Short-Term Results Good

The short-term results of tuberculosis treatment in this group of patients is extraordinarily good. Alcoholism and inadequate diet have greatly lowered their resistance to tuberculosis and when these conditions are corrected they respond, sometimes almost miraculously, to proper treatment.

The long-term results of treatment of tuberculosis and of efforts directed toward general rehabilitation are discouraging. The results in treating alcoholism in persons who wish to continue to drink heavily are no better than those reported by others. While a few men have actually been rehabilitated, the majority return to their old pattern of life on discharge and the tuberculosis relapse rate is high. Another possible factor in relapse is a high proportion of refusals of surgery by these men who have a life-long pattern of attempting to avoid the unpleasant aspects of reality.

Altogether this program seems worthwhile. It protects the community from a great many sources of infection. It provides care and treatment for a great many men who need it badly.

It may be objected by some that one provides a doubtful service if it must be given under lock and key. Certainly, the patients often complain bitterly about being deprived of their liberty and about everything else connected with their treatment. But rather frequently they ask to be kept on the locked ward when they are eligible for transfer to some other part of the hospital. If they run away from the hospital, they often return voluntarily after a short fling. If they do not return, they usually are arrested for drunkenness or by some means arrange matters so that they are certain to be brought back. They very rarely leave the state or make any real effort to escape return to the hospital. Their actions speak louder than their words.

AMERICAN BOARD OF PHYSICAL MEDICINE AND REHABILITATION

The next examinations for the American Board of Physical Medicine and Rehabilitation will be held in Philadelphia, June 5 and 6, 1955. The final date for filing applications is March 1, 1955. Applications for eligibility to the examinations should be mailed to the Secretary, Dr. Earl C. Elkins, 30 N. Michigan Ave., Chicago 2, Illinois.

PERSONALS AND NEWS ITEMS

Dale and Mrs. Alford were in New York, September 17th through the 25th, attending a meeting of the American Academy of Ophthalmology.

Tom L. Dunn, Hamburg, has leased the Calhoun County Hospital and will operate it as a private clinic.

John B. Kirkley, Jonesboro, left September 15 for the armed service at Ft. Sam Houston.

Executive Secretary, Paul Schaefer, attended the AMA's Public Relations Institute in Chicago, September 1 and 2. Three hundred Medical Society representatives were in attendance.

September 13 was celebrated in Corning as "Dr. N. J. Latimer Day" honoring the man who has practiced medicine for 60 years. Latimer was one of the members of the first Arkansas State Medical Board, and he has been an active and working member of the Arkansas Medical Society most of his professional years.

Eva Dodge, Little Rock, Associate Professor of Obstetrics, has been named chairman of the Family Welfare and Child Care Division of the Greater Little Rock Community Council for the coming year. Woodbridge E. Morris, Little Rock, has been appointed chairman of the Health Division of the same Council.

Edward J. Novak, Tuckerman, President of the Jackson County Medical Society, has been ordered to active duty with the navy. He reports at New Orleans.

The following members of the Southwestern Surgical Congress were among those in attendance at the meeting in Oklahoma City, September 20-22, 1954: John W. Jones, Texarkana; J. B. Wharton, El Dorado; Carl Wilson, Ralph Crigler, W. E. Knight, Wright Hawkins, Fred H. Krock, Marlin Hoge, Fort Smith; John H. Wilson, Magnolia; E. J. Stroud, Jonesboro; H. Fay H. Jones, J. A. Buchman, Harry Hayes, J. W. Downs, Little Rock; Alfred Hathcock, Fayetteville; A. B. Dickey, Booneville; J. P. Price, Monticello; Hunter Causey, Pine Bluff; Frank Burton, Hot Springs; Friedman Sisco, Springdale; Joe Rushton, Magnolia, Arkansas. Louis Lambiotte, Fort Smith, appeared as the Internist on a Panel Discussion at the same meeting.

Billy V. Hall, Gravette, is building a 14-bed clinic which he will open about January 1st.

L. H. McDaniel, President-Elect of the Arkansas Medical Society, Tyronza, addressed the convocation of the University of Arkansas School of Medicine at the official opening of school, September 20.

Rufus D. Haines, Paragould, was elected chairman of the Board of Directors of the Community Hospital, and Charles Bowers, Paragould, its treasurer.

Jack W. Thicksten is moving his offices from Booneville to Conway early in October.

W. A. Hudson, Jasper, with Mrs. Hudson, is in Europe for attendance at the world medical assembly in Rome. They are due to return late in October. While they make a part-time home in Jasper, Dr. Hudson has offices in Detroit, Mich.

A visiting physician, Charles V. Perrill, who heads the Clara Swain Hospital in Bareilly, India, spoke to Methodist leaders in several Arkansas cities during September. Dr. Perrill has many friends in Arkansas. He has been in medical missionary work in India for about 15 years.

$352,000 has been allotted to Arkansas under the Hill Burton Construction Act. Passed by the last Congress, of this amount $104,000 is earmarked for diagnostic treatment centers and $72,000 for rehabilitation facilities and nursing homes.

Newton J. Latimer was honored at his home town by the Young Men's Civic Club of Corning by "Dr. Latimer Day" at which one of the oldest members of the Arkansas Medical Society recounted some of his experiences in some 60 years of general practice.

Robert G. Carnahan, Little Rock, was elected councilor for Arkansas in the Mid-Continent Psychiatric Association which has branches in Arkansas, Kansas, Oklahoma and Missouri, at a recent meeting.

Howard A. Dishongh, veteran Pulaski County coroner, is the new president of the National Association of Coroners since his election in Little Rock at their meeting in August.

Physicians on the program of the State Law Institute held at the University of Arkansas October 7, 8 and 9, were: Joe F. Shuffield and Anderson Nettleship, Little Rock, and Earle A. McKelvey, Paragould.

James W. Marsh, Warren, moved into new offices on October 1.

F. Walter Carruthers, Little Rock, attended the three-day meeting of the Clinical Society of Bone and Joint Surgeons which was held in Chicago, in October.

H. Fay and Mrs. Jones, Little Rock, attended a meeting of the Southwestern Surgical Congress in Oklahoma City in September. He is a member of the founders group of the Congress.

James W. Harrison of Texarkana has recently joined the Society through the Miller County Medical Society.

Lloyd F. Gregory of Little Rock has become a member of the Society through the Pulaski County Medical Society and Richard A. Cuonzo, West Memphis, has also become a member through the Crittenden County Medical Society.

J. W. Walker has opened an office in Tuckerman for the general practice of medicine.

Roger P. Edmondson, Springdale, has been taking post-graduate work in Chicago during October.

PROCEEDINGS OF SOCIETIES

Alumni Post-Graduate Medical Assembly U. of A. School of Medicine

The third Post-Graduate Medical Assembly sponsored by the newly organized Alumni Association of the University of Arkansas School of Medicine was held November 5 and 6, 1954, so that it might coincide with the Rice vs. Arkansas football game on the afternoon of Saturday, November 6, and that it might just precede the meeting of the Southern Medical Association in St. Louis, November 8, 1954. Also, the meeting coincided with a meeting of the Arkansas Urological Society on November 5, 1954. It should be remembered that the attendance will result in credit for members of the Academy of General Practice, and that the costs of transportation are tax-deductible.

The guest of honor was William O. Arnold, Internist, Scott and White Clinic, Temple, Texas, an alumnus of the Arkansas School of Medicine. Other participants on the program were Elmer Purcell, Department of Medicine, University of Arkansas School of Medicine, Harvey Shipp, Little Rock, Arkansas, and David M. Yocum, El Dorado, Arkansas. The panel of men listed discussed pulmonary diseases.

The program follows:

Friday, November 5, 1954

4:00 p. m.—Convocation of students, amphitheater of the Medical School—W. O. Arnold, Temple, Texas.

Evening—Social. M. J. Kilbury, Sr., and M. J. Kilbury, Jr., Little Rock.

Saturday, November 6, 1954

8:30 a. m.—Registration, University of Arkansas School of Medicine.

9:00 a. m.—Welcome. Art Martin, Dean Nicholson, Little Rock, and Dusty Rhodes, Fayetteville, Ark.

9:30 a. m.—Address by Dr. Arnold.

10:15 a. m.—Intermission.

10:30 a. m.—Panel discussion. Moderator, Elmer Purcell, Little Rock. Panel members, W. O. Arnold, Harvey Shipp, Little Rock, and David Yocum, El Dorado.

11:15 a. m.—Business session.

12:00 noon—Adjourn.

1:00 p. m.—Tour of new Medical School site.

2:00 p. m.—Football, Rice vs. Arkansas, War Memorial Stadium.

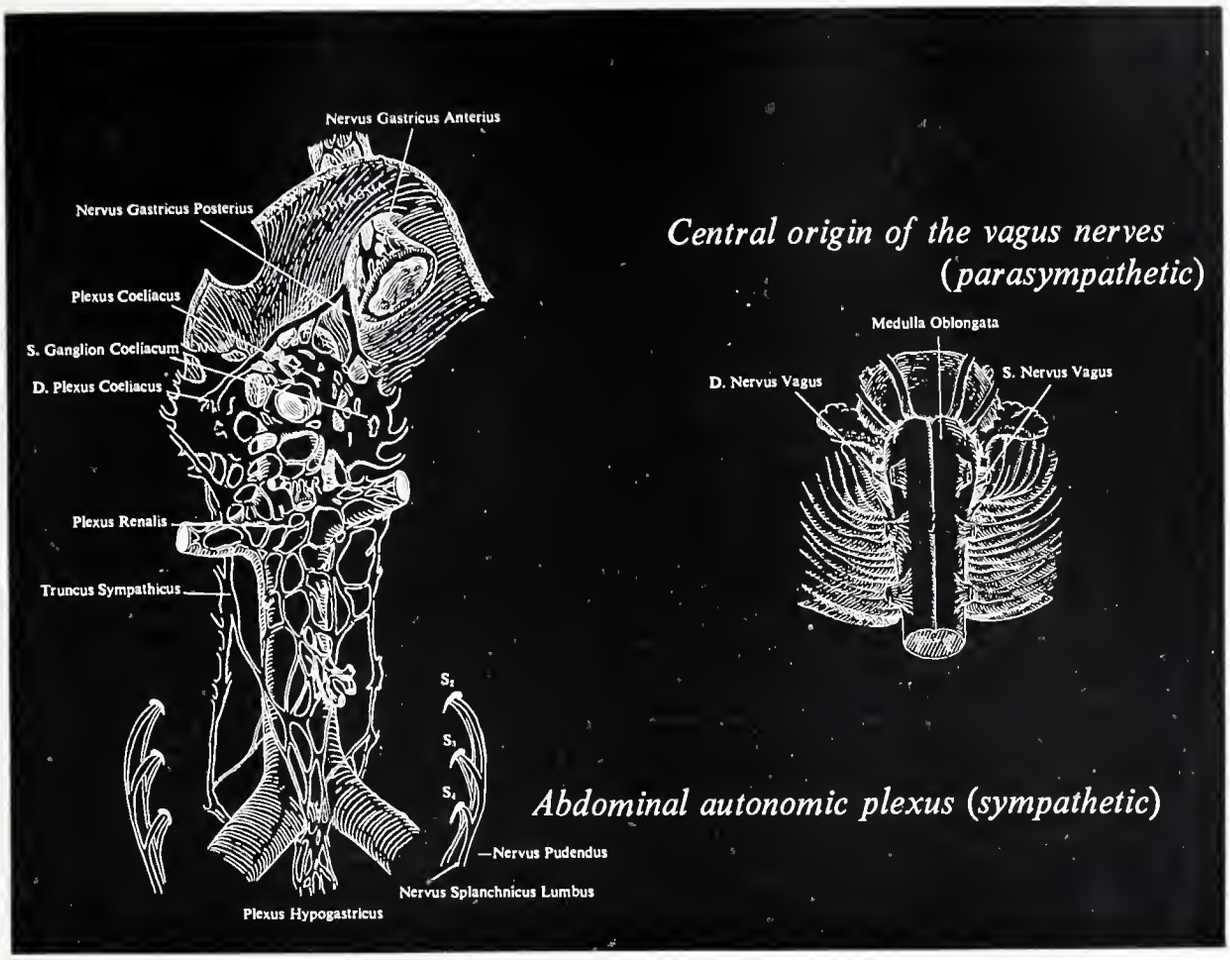
Joe A. Norton, Sec.-Treas.
Medical Alumni
U. of A. School of Medicine

Dr. George Lull to Camden

The Fifth District Medical Society will meet in dinner session at the Camden Hotel in Camden Thursday night, November 11. George Lull, Secretary-Manager of the American Medical Association, of Chicago, will be the principal speaker. W. R. Brooksher, President of the Arkansas Medical Society, will also appear on the program. All members of the Arkansas Medical Society are invited to this meeting.

R. B. Robins, Secretary

The Third Councilor District Medical Society met October 28 at Brinkley with J. P. Williams as host. Marion S. Craig, James Headstream and Henry Hollenberg of Little Rock, and Pervis Milnor, Memphis, provided the program and panel discussion.



Control of Gastric Motility and Spasticity in Peptic Ulcer with Banthine®

"The need[1] for suppressing gastric motility and spastic states is . . . fundamental in peptic ulcer therapy. Since the cholinergic nerves are motor and secretory to the stomach and motor to the intestines, agents capable of blocking cholinergic nerve stimulation are frequently used to lessen motor activity and hypermotility."

Banthine[2] "has dual effectiveness; it inhibits acetylcholine liberated at the postganglionic parasympathetic nerve endings and it blocks acetylcholine transmission through autonomic ganglia."

It has been shown[1] to diminish gastric motility and secretion significantly as well as intestinal and colonic motility.

The usual schedule of administration in peptic ulcer is 50 to 100 mg. every six hours, day and night, with subsequent adjustment to the patient's needs and tolerance. After the ulcer is healed, maintenance therapy, approximately half of the therapeutic dosage, should be continued for reasonable assurance of nonrecurrence.

Banthine® (brand of methantheline bromide) is supplied in: Banthine ampuls, 50 mg.—Banthine tablets, 50 mg.

It is accepted by the Council on Pharmacy and Chemistry of the American Medical Association. Searle Research in the Service of Medicine.

---

1. Zupko, A. G.: Pharmacology and the General Practitioner, GP 7:55 (March) 1953.

2. McHardy, G. G., and Others: Clinical Evaluation of Methantheline (Banthine) Bromide in Gastroenterology, J.A.M.A. *147*:1620 (Dec. 22) 1951.

Arkansas Academy Completes Fall Seminar

One hundred twenty-seven physicians registered at the two-day Fall Seminar in Little Rock, October 6-7, where an excellent program was presented by visiting physicians and by members of the faculty of the University of Arkansas Medical School.

W. B. Hildebrand, Menasha, Wisconsin, was a feature speaker of the first day's luncheon, and Prof.-Dr. Narno Dorbecker, Chief Radiologist at the Institute of Cardiology, Mexico City, Mexico, gave a classical lecture on Coarctation of the Aorta.

Other participants on the program were: Harry Wilkins, Oklahoma City; Louis T. Tyars, St. Louis; A. H. Robinette, Cleveland, Ohio; Worth M. Gross, Tulsa; Wm. K. Keller, Louisville; Shade Neely, Muskogee; A. Seldon Mann, New Orleans; C. Joseph Stetler, Chicago, and the following from Little Rock: Frances S. Brennecke, John T. Herron, Mr. Eugene Warren, Guy Sutherland, and E. Loyd Wilbur.

Guy U. Robinson of Dumas was elected president of the Southeast Arkansas Medical Society at the monthly scientific meeting held in McGehee, September 20.

Major Smith of Dermott was elected vice president and Vann Binns of Wilmot was chosen as secretary. Conducting a panel discussion for the Society were Lawrence Zell and ..... Pemberton of Little Rock, and Charles Anderson of Pine Bluff. The discussion was on facial malignancies.

The annual meeting of the Tenth Councilor District, Arkansas Medical Society, was held September 22 in Clarksville. This district consists of nine counties, Johnson, Pope, Franklin, Crawford, Sebastian, Scott, Logan, Yell and Perry.

Guy Shrigley, Clarksville, out-going president, presided as master of ceremonies. David Gibbons of Ozark is the retiring secretary-treasurer.

During the business session, Louis Whitaker, Fort Smith, was elected president, and Morton Wilson, also of Fort Smith, was named secretary-treasurer.

Lewis Hyatt, Monticello, was the featured speaker, using as his subject, "Public Relations."

A joint meeting of the Arkansas Chapters of the American College of Surgeons and the Southwest Surgical Congress was held October 15 in Little Rock. T. P. Foltz, Fort Smith, presided. Program contributions were made by Roy I. Millard, Russellville, Ruth Ellis Lesh, Fayetteville, Carl L. and Morton C. Wilson, Fort Smith, Robert Jones, Little Rock, Donald E. King, Little Rock, James M. Headstream, Little Rock, Ralph E. Rowen, Little Rock, W. E. Knight, Fort Smith, and Joseph A. Buchman, Little Rock.

P. O. Thomas, Sec.

Election of officers at the Tri-State Medical Society in Longview, Texas, last October, elevated W. B. Harrell, Texarkana, to President. Karlton Kemp, Texarkana, was elected secretary-treasurer, and the next meeting was scheduled for Texarkana. Frank G. Thibault, El Dorado, is a director for Arkansas of the organization.

Karlton Kemp, Sec.

WOMAN'S AUXILIARY NEWS

The Women's Auxiliary to the Jefferson County Medical Society began their year with a coffee given at the home of Mrs. J. Clyde Hart. Mrs. Hoyt Choate, of Little Rock, state president of the Woman's Auxiliary to the Arkansas Medical Society, presided over the school of instruction. Following this a luncheon was held at the Pines Hotel in the Terrace Room. Mrs. Ross Maynard, president of the Women's Auxiliary to the Jefferson County Medical Society, introduced Mrs. Hoyt Choate, who discussed "New Features for the Auxiliary" and related her experiences at the American Medical Association meeting in San Francisco. Mrs. Russell James, R.N., representing the Pine Bluff District Nurses' Association, was introduced and plans were made for a tea to be held on October 17, honoring the nursing profession, which will climax National Nurse Week.

Our State President, Mrs. Hoyt Choate, has been quite busy visiting the county auxiliaries. She has visited Texarkana, Pine Bluff, Rogers, Helena, Russellville, and the Regional Conference for Northwest in Fayetteville, which was very well attended.

Southern Medical Association convention will convene in St. Louis, Missouri, November 7 to 11. Mrs. Mason Lawson, President-Elect of the Woman's Auxiliary to the American Medical Association, will be an honored guest. Mrs. Hoyt Choate, state President, is the Southern representative from the State Auxiliary. Mrs. Louis Hundley will be installed as President of the Woman's Auxiliary to the Southern Medical Association.

U. C. MEDICAL CENTER LIBRARY
DEC 27 1954
San Francisco, 22

DECEMBER 1954

THE JOURNAL OF THE ARKANSAS MEDICAL SOCIETY

VOL. LI No. 7

FORT SMITH, ARKANSAS

consider
ILOTYCIN
(ERYTHROMYCIN, LILLY)
FIRST

...because its antibiotic spectrum is unexcelled

'Ilotycin' is effective against over 80 percent of all bacterial infections; yet the bacterial balance of the intestine is not significantly disturbed.

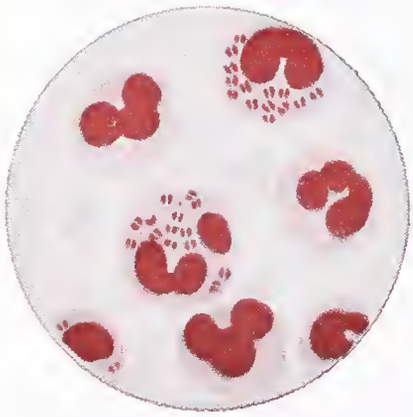
Lilly

from the literature...

"The value of CHLOROMYCETIN in the treatment of infections due to most bacteria, the pathogenic rickettsiae, and many of the large viruses has now been well established."[1]

in typhoid fever

"Our experience...and many others all show that chloramphenicol [CHLOROMYCETIN] has an established place in the treatment of typhoid fever."[2]

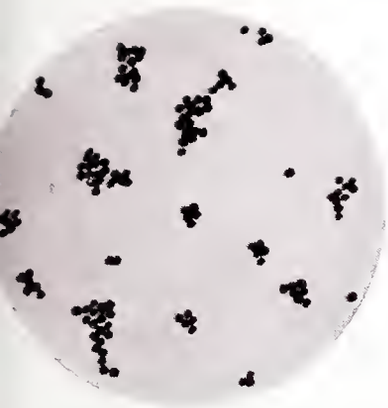


in meningitis

"At the present time chloramphenicol [CHLOROMYCETIN] is recognized as a potent antibiotic whose ease of administration and prompt diffusion into serum and spinal fluid makes it a particularly useful agent in the treatment of many forms of purulent meningitis."[3]

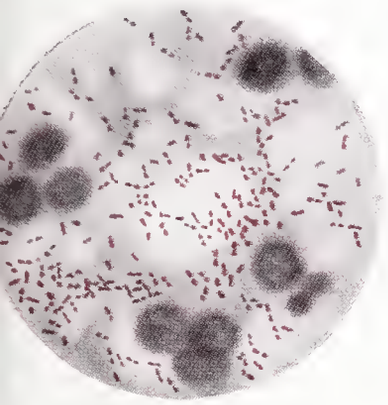
Chloro

(1) Yow, E. M.; Taylor, F. M.; Hirsch, J.; Frankel, R. A., & Carnes, H. E.: *J. Pediat.* **42**:151, 1953. (2) Dodd, K.: *J. Arkansas M. Soc.* **10**:174, 1954. (3) Hanbery, J. W.: *Neurology* **4**:301, 1954. (4) Miller, G.; Hansen, J. E., & Pollock, B. E.: *Am. Heart J.* **47**:453, 1954. (5) Keefer, C. S., in Smith, A., & Wermer, P. L.: Modern Treatment, New York, Paul B. Hoeber, Inc., 1953, p. 65.



in bacterial endocarditis

"Within ten days [after therapy with CHLOROMYCETIN was begun] there was a dramatic improvement in the patient's clinical appearance and the sedimentation rate and temperature became normal."[4]



in rickettsial diseases

"Chloramphenicol [CHLOROMYCETIN] has been used with striking success in patients with scrub typhus, murine typhus, Rocky Mountain spotted fever, and epidemic typhus."[5]

mycetin®

(Chloramphenicol, Parke-Davis)

CHLOROMYCETIN is a potent therapeutic agent and, because certain blood dyscrasias have been associated with its administration, it should not be used indiscriminately or for minor infections. Furthermore, as with certain other drugs, adequate blood studies should be made when the patient requires prolonged or intermittent therapy.

MEDICAMENTA VERA · P & CO.

PARKE, DAVIS & COMPANY
DETROIT 32, MICHIGAN

THE

Journal

OF THE

Arkansas Medical Society

Owned by

THE ARKANSAS MEDICAL SOCIETY

And Published Under Direction of the Council

FOUNT RICHARDSON, M.D., Editor

316 West Dickson Street — Fayetteville, Arkansas

MR. PAUL C. SCHAEFER, Business Manager

215 Kelley Bldg. — Fort Smith, Arkansas

The Advertising policy of this JOURNAL *is governed by the rules of the Council on Pharmacy and Chemistry of the American Medical Association.*

EXCLUSIVE PUBLICATION—Articles are accepted for publication on the conditions that they are contributed solely to this JOURNAL.

COPYRIGHT, 1954—By The JOURNAL *of the Arkansas Medical Society.*

NEWS—Our readers are requested to send in items of news, also marked copies of newspapers containing matter of interest to the membership.

OFFICERS OF THE ARKANSAS MEDICAL SOCIETY

W. R. BROOKSHER, President ..... Fort Smith
L. H. McDANIEL, President-Elect ..... Tyronza
T. P. FOLTZ, First Vice-President ..... Fort Smith
ELDON FAIRLEY, Second Vice-President ..... Wilson
R. H. WHITEHEAD, SR., Third Vice-President ..... DeWitt
J. J. MONFORT, Secretary ..... Batesville
DANIEL H. AUTRY, Treasurer ..... Little Rock
T. DUEL BROWN, Speaker, House of Delegates ..... Little Rock
C. C. LONG, Vice-Speaker ..... Ozark
MR. PAUL C. SCHAEFER, Executive Secretary
215 Kelley Bldg., Fort Smith

COUNCILORS

First District—JOE VERSER ..... Harrisburg
Second District—HUGH R. EDWARDS ..... Searcy
Third District—J. MAX ROY ..... Forrest City
Fourth District—L. K. HUNDLEY, Chairman ..... Pine Bluff
Fifth District—D. E. WHITE ..... El Dorado
Sixth District—HARRY E. MURRY ..... Texarkana
Seventh District—H. KING WADE, JR ..... Hot Springs
Eighth District—H. ELVIN SHUFFIELD ..... Little Rock
Ninth District—FOUNT RICHARDSON ..... Fayetteville
Tenth District—J. M. KOLB ..... Clarksville

VICE-COUNCILORS

First District—WAYNE WORKMAN ..... Blytheville
Second District—JOHN SNEED ..... Conway
Third District—J. P. WILLIAMS, JR ..... Brinkley
Fourth District—H. W. THOMAS ..... Dermott
Fifth District—GEORGE BURTON ..... El Dorado
Sixth District—CHARLES YARBOROUGH ..... Texarkana
Seventh District—RANDOLPH ELLIS ..... Malvern
Eighth District—ROBERT D. JONES ..... Little Rock
Ninth District—LEE A. DEAN ..... Rogers
Tenth District—LOUIE A. WHITTAKER ..... Fort Smith

Notice on Form 3578-P to be sent to the Arkansas Medical Society, 215 Kelley Building, Fort Smith, Arkansas. Published monthly under direction of the Council, Arkansas Medical Society, at Fort Smith, Arkansas. Vol. 11, No. 7. Subscriptions $3.00 a year. Single copies, 50 cents. Entered as second-class matter, Sept. 23, 1947, at the post office at Fort Smith, Arkansas, under the Act of Congress of March, 1879. Acceptance for mailing at special rate of postage provided for in Section 1103, Act of October 3, 1917, authorized August 1, 1918.

• SPECIAL FEATURES

Committee on Cancer Control .. 155

Advances in Care of Common Pediatric Urological Problems. 156

Industrial Problems in Ophthalmology 160

The Outlook for Man 163

• FEATURES

Obituary 165

Editorial 166

Arkansas Traveling 168

Coming Events 168

Tuberculosis Abstracts 169

Personals and News Items 170

Proceedings of Societies 171

Book Reviews 172

The JOURNAL
OF THE ARKANSAS MEDICAL SOCIETY
PUBLISHED MONTHLY UNDER DIRECTION OF THE COUNCIL

Vol. LI December, 1954 No. 7

Committee on Cancer Control

C. A. ARCHER, Chairman, Conway

BULLETIN TO COUNTY MEDICAL SOCIETIES

The Committee on Cancer Control is desirous of furthering professional education in cancer in order that physicians may be alerted to the increasing importance of recognition and treatment in this disease.

The Committee will supply motion picture films and furnish speakers on request of county or district medical societies and urges each society to conduct one meeting each year devoted to the consideration of malignant diseases.

Requests for such programs should be addressed to C. A. Archer, M.D., Conway, Arkansas.

ADVANCES IN CARE OF COMMON PEDIATRIC UROLOGICAL PROBLEMS

HORACE V. MUNGER
Department of Urology, Lincoln General Hospital, Lincoln, Nebraska

In the next few minutes some observations on the care of the Pediatric Urological cases will be made.

First, let us consider some of the factors which fall in the category of diagnostic aids. Generally the investigation and management of these patients parallels that pattern followed in caring for the adult. In the process of physical examination of an infant or small child palpation of the kidneys is usually unsatisfactory when done with the patient supine. If he be rolled over and bimanual palpation then done a much more satisfactory palpation of the kidney results. Parenthetically the most common cause of a mass felt in this area is not liver or Wilm's tumor but hydronephrosis. Do not forget that the one time valuable information is obtained from rectal examination offsets the many other times when rectal examination is negative. A cystogram was obtained on a six-year-old boy who had been treated for several weeks as a behavior problem because he continually wet his pants and was irritable and uncooperative. Eventually he was examined by a pediatrician who found a mass on rectal examination. He was immediately referred and work up revealed the marked rectal intrusion by a rubbery prostatic mass, a distended bladder and the marked elevation of the bladder seen on the cystogram. The diagnosis, sarcoma of the prostate. Palliative cystostomy was done. The prognosis was hopeless. A chest film was taken three months later, the extent of the metastases was widespread.

Excretory urograms in children have been less satisfactory than in adults because of difficulties in obtaining intravenous studies in infants and the usually poor concentration of dye obtained by intramuscular or subcutaneous administration of the contrast media. One aid has given us better visualization of pyelograms by providing what amounts to a double contrast study.[1] If formula is given ten minutes before the dye is administered, (or if the child is larger he may be given milk or Coca-Cola) a large gas bubble will fill the stomach area thus providing excellent contrast (Fig. 1). This pyelogram demonstrates this excellent contrast. This three-month-old child was seen because of repeated episodes of urinary tract infection. Cystoscopic study revealed obstruction at the uretero-vesical juncture as the cause of the dilatation you see. Since nephroureterectomy the child has remained well.

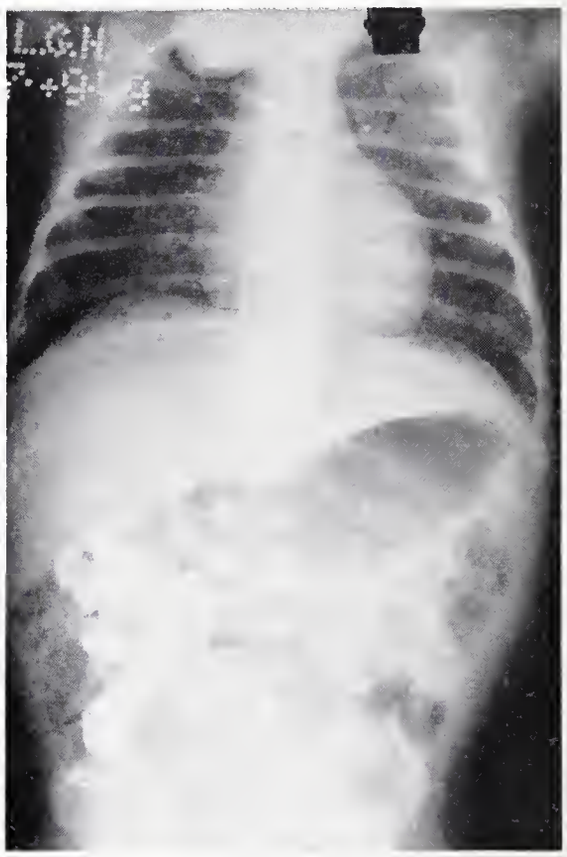


Fig. 1

When the contrast media cannot be given intravenously and subcutaneous administration is done delayed appearance and poor concentration usually result. Astley[2] has shown that by adding 1,000 turbidity reducing units of hyaluronidase to the dye prompt absorption will result. In our experience excellent concentration equal to that obtained upon intravenous administration will be noted by 20 minutes. We are now using 70% urokon sodium for intravenous films in all children under four and obtain a superior degree of concentration in a high percentage. In infants we have found that the recommended dose of 1.5 c.c. for each pound of body weight is very satisfactory. If any allergic history is obtained we give 10 mg. chlortrimeton prior to examination.

One of the more common problems confronting the general practitioner, pediatrician and urologist alike, is that of enuresis. Statistics as to the incidence of organic pathology in relation to bed

Read before the Pediatric Section of the Seventy-eighth Annual Session, Arkansas Medical Society, Fort Smith, April 19, 1954.

wetting vary from the British figure of three per cent to some American figures as high as sixty-five per cent. Our figures approximate ten per cent. Since the renal damage which may ensue is so serious we feel strongly that any enuretic should have as minimal workup prior to institution of therapy, physical examination, catheterization for residual urine and excretory urograms. Cook[3] maintains that the incidence of behavior disorders is high in this group of patients. He notes that many of these children are deep sleepers and advocates giving 25 mg. ephedrine at bedtime to raise the sleep threshold. Roland[4] supports this contention and suggests that deep sleep suppresses the inhibitory influence of the cerebral cortex on the hypothalamic region. This is the region which induces bladder contraction upon stimulation by spinal reflexes which seek to initiate micturition. Two approaches may be tried. First cortical stimulation as advocated by Cook can be attained by D-amphetamine. This drug has no side effects and is used each night at bedtime in a 5 mg. dose. The child's alarm is set for four hours later. The desired effect is obtained when the child rouses, turns off the alarm and goes to the toilet. We do this for ten days and if at that time the response has not been satisfactory the dose is doubled. Second it is rational to assume that the spinal reflex can be inhibited if bladder capacity can be increased without increasing detrusor tone.

Fig. 2

In those children who do not sleep so deeply we use the following regime. At bedtime 15 mg. Probanthine is given after the child has emptied the bladder and the regime continued for two weeks. If results are not entirely satisfactory the dose is increased to 30 mg. Again let me emphasize that therapy is begun only after the absence of organic pathology has been proved. Our experience is contrary to that of Cook, in as much as we but rarely see enuresis as the component of a behavior problem. We have opposed the use of conditioning apparatuses chiefly because they have been exploited commercially at an unreasonably high rental figure. (Fig. 2.) This pyelogram of a five-year-old boy who was referred because of enuresis demonstrates a left tract duplication anomaly with secondary infection. Treatment of his enuresis consisted of heminephroureterectomy. He has been well since.

Anomalies of the urinary tract may involve any part of the tract and demand systematic urological investigation because of the tendency to multiplicity. When a child is found to have an anomaly of the genitals it is well to remember that he has one chance in three of having a coexisting upper tract anomaly also. We should also be aware of the frequent association of skeletal, intestinal and genitourinary anomalies. The importance of seeking for genitourinary anomalies is evident when we consider that 10 to 12% of all individuals have these anomalies and that most of them will result in urinary stasis which always results in infection. Meatal stenosis is the most common anomaly. Frequently parents are disturbed following meatotomy because of secondary bleeding. This can be precluded by clamping the lower angle of the meatus with a mosquito forcep for five minutes prior to meatotomy. In no instance have we had bleeding following the use of this preliminary clamping. Very frequently children who are seen because of urinary tract infection are found to have congenital bladder neck obstruction. Relief of this obstruction by resection with the miniature resectoscope has largely been replaced by the retropubic approach as advocated by Millin. Precise excision of the bladder neck under excellent vision is possible in contrast to the inadequate vision and more difficult hemostasis of the endoscopic procedure. (Fig. 3.) This pyelogram represents the dilatation destruction of the upper tract which resulted in an infant as the result of bladder neck obstruction. (Slide 6.) This kodachrome of the surgical specimen reveals the marked dilatation of the kidney and ureter and the next (slide 7) a close-up demonstrates the inflammatory reaction. Sections revealed very severe damage which accounted for the lack of function.

Fig. 3

The infinite number of operations devised for the correction of hypospadias is evidence that an entirely satisfactory procedure has been lacking. The criteria of a successful operation are that the penis be straight, that urination is satisfactory and that the organ is capable of the reproductive act. The ventral curvature seen in hypospadias is the result of fibrous tissue which replaces the corpus spongiosum. As the penis grows the ventral bowing becomes more pronounced. For this reason correction of the chordee should be done early. We prefer the technic devised by Nesbit[5] and believe it should be done at about one year. (Fig. 4, 5, 6.) This procedure consists of a circumferential incision just below the corona. The skin is then retracted and the fibrous tissue completely excised if this be done the penis is then straight. The skin is then drawn up and a dorsal button hole made. The glans is drawn through the button hole so that the distal portion can be brought down and becomes the skin covering of the ventral surface. The resulting defects are closed with fine sutures, the coronal cuff to the edge of the button hole and the remaining defect transversely. Approximately one year later the second stage is done, this interval may be lengthened but should not be deferred until the child has reached school age. Denis Browne[6] perfected the techic to be described to correct the hypospadias per se. The principle of this operation is to provide a strip of intact buried skin from which epithelium will spread to form a tube. This one stage procedure is divided into four distinct steps. (Fig. 7.) The first step is diversion of the urinary stream by perineal

advantageously at second stage. The normaley

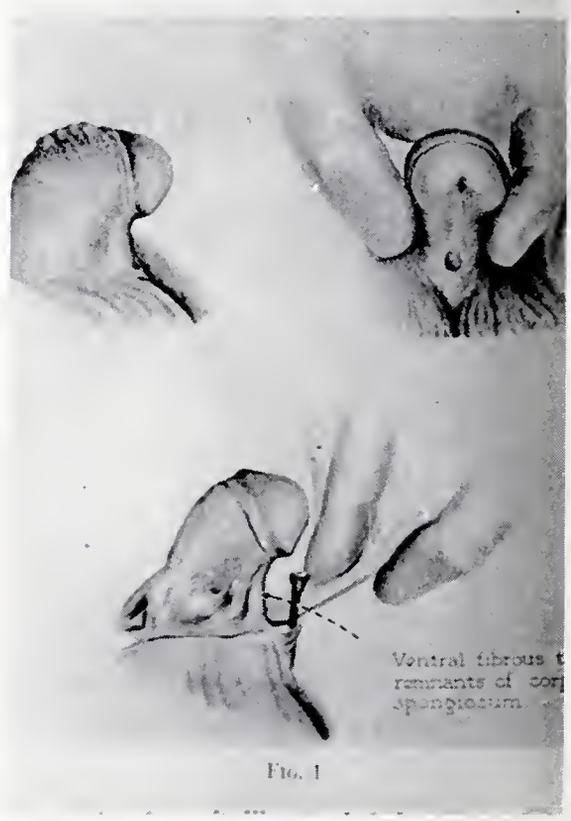


Fig. 4

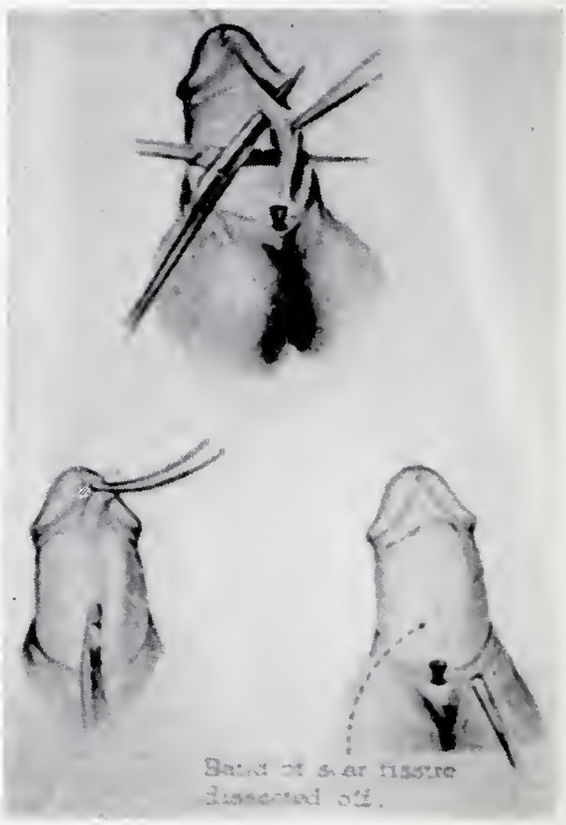


Fig. 5

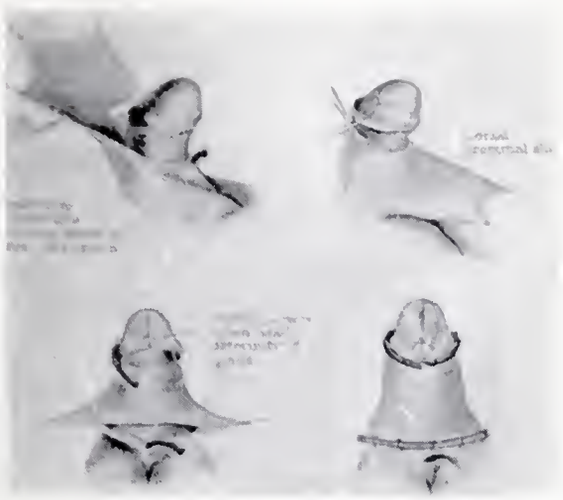


Fig. 6

urethrostomy. We prefer introducing the catheter then grasping the tip with a curved hemostat the latter is then pointed at the bulbomembranous urethra and incision is made against it with the cautery knife. The tip of the catheter is then grasped with a second forcep and withdrawn the proper amount and anchored to the perineal skin with two sutures. The second step is the formation of the skin strip. This is accomplished by making parallel incisions as shown so that the strip of skin between is as wide as the circumference desired for the tube. Two triangular areas on the ventral lateral surface of the glans are denuded with the apices at the level desired for the new meatus. The lateral flaps are undermined to preclude any tension at time of closure and a stab wound is made inferiorly at each side to provide an escape route for serum which may collect. The third step is to make a relaxing incision the entire length of the penis on the dorsal surface. It is important to carry this well up over the pubis to preclude any tension near the old meatus. The fourth step is to approximate the lateral flaps over the strip of skin thus burying it. A row of 00 chromic catgut interrupted sutures is placed approximately a half of an inch from the skin edges and fixed without tension by beads. The skin edges are then closed with interrupted 0000 chromic sutures care being taken to evert the edges. The dorsal slit area is covered with Furacin impregnated gauze and the entire penis dressed with a light compression bandage.

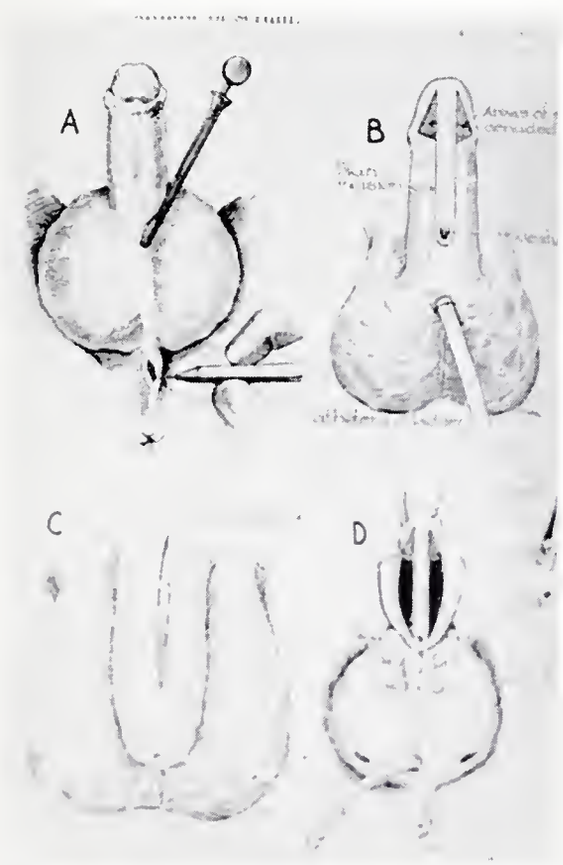


Fig. 7

Hydronephrosis resulting from ureteropelvic obstruction is most commonly due to aberrant vessel. (Slide 13). This pyelogram illustrates such an obstruction in a twelve-year-old girl. Intrinsic obstruction also occurs and may be result from stenosis of the upper limit of the ureter or from hypertrophy at the juncture. Plastic procedures for correction of these defects have been greatly aided by the advent of polyethylene tubing which does not accumulate urinary salts as does rubber hence prolonged splinting and intubation are more effective. Recently Ormond Culp has presented a technic of pyeloplasty to correct this type of defect which is both simple and effective. The incision which ascends the ureter, is carried up the pelvis a distance equal to the ureteral incision then is curved down to the dependent area thus forming a flap. The flap is turned down without rotation and its edge sutured to the medial edge of the ureter thus widening the posterior wall. The other edge of the flap is then approximated to the other edge of the ureter thus forming the anterior wall and the closure is continued on up to entirely close the pelvis. A polyethylene tube is introduced to serve as a splint and a nephrosotomy tube is placed to provide drainage.

The treatment of urinary tract infections resolves itself into two distinct steps. The first is concerned with the determination of the presence of any obstruction and its correction, the second with eradication of the infection. In our experience time and money is saved the patient if cultures and sensitivity tests are uniformly used. We have found more often than not that the causative organism does not respond to the

type of medication we have supposed it would. As evidence of this let me cite the fact that we no longer have sensitivity for penicillin included by our laboratory because of the negligible number of times any sensitivity to it has been shown. To date we have been disappointed in the results obtained with Erythromycin also. Furadantin, Tetracycline, Terramycin, Aureomycin and Streptomycin have proved of greater value than any other medication. Recently a pediatric suspension of Furadantin has been made available. The drug is supplied in a suspension containing 5 mg./c.c. and the dose is from 5 to 10 mg./kg./day. Thus a 40-pound child would receive one teaspoonful four times daily. This drug has the advantage over the broad spectrum antibiotics of not upsetting the intestinal flora but has the disadvantage of occasionally producing nausea unless care is taken to give it with or immediately following the ingestion of food.

Examination of these little patients is sometimes opposed by parents because anesthesia must be employed. Followup urethral dilatations and endoscopy in the office are now easier to accomplish with the use of Trilene. This gas can be safely administered for procedures of short duration and is of great value since immediate recovery occurs with minimal reaction. It is the usual rather than the exceptional thing to have these little patients leave the office after having received Trilene and go directly to the restaurant to collect the ice cream promised them if they would be good. If relaxation is required Trilene is not recommended. It is our practice to hospitalize any child who will need anesthesia for more than a few moments in order to provide more satisfactory anesthesia. To prevent the apprehension incident to going to surgery the use of rectal pentothal as advocated by Lundy[7] is advised. This technic consists of instilling 10 per cent Sodium Pentothal rectally in the amount of 1 c.c./5 lbs. body weight. The rectal instillation is administered in the pediatric ward and the child is then taken to surgery asleep. If extensive work is to be done Atropine is given and our anesthesiologist augments the rectal Pentothal with nitrous oxide inhalation. We do not attempt spinal or intravenous anesthesia in children at all except for intravenous Pentothal induction in older children.

Summary

Some observations on improved diagnostic aids, enuresis, technics in correcting some common anomalies, the care of urinary tract infections and anesthesia in pediatric urologic patients have been offered.

BIBLIOGRAPHY

1. Matthei, L. P.; Tr. S. C. S. A. U. A. P. 99, 1949.
2. Astley, Roy; J. Fac. Radiologists, 3:286-289, April, 1952.
3. Cook, Edward N.; J. A. M. A., 144:1421-1423, Dec. 23, 1950.
4. Roland, Samuel, I.; J. Urol., 71:216-218, Feb., 1954.
5. Nesbit, Reed; J. Urol., 45:699-702, May, 1941.
6. Browne, Denis; Post-Grad. Med. J., 25:367, 1949.
7. Lundy, John S.; J. Urol., 67.745-749, May, 1952.

INDUSTRIAL PROBLEMS IN OPHTHALMOLOGY

GARDNER H. LANDERS *
506 West Faulkner, El Dorado, Arkansas

In dealing with industrial problems in ophthalmology, we must consider those encountered in the treatment of eye injuries and also those presented from an administrative or medico-legal standpoint. We realize that these problems are different with each practicing ophthalmologist and they, of course, will also vary with each section of the country.

Injuries

Volumes have been written on the treatment of eye injuries in industry. It is our intention to mention a few points which have been valuable to us in the treatment of some of these cases.

Superficial Foreign Bodies

Every industrial injury, even though minor in character, must be considered from the standpoint of complications and later possible medico-legal controversy. We must take a detailed history, including in it the account of the happening as given by the patient. A record also must be made of the visual acuity. It is our routine to instill an anesthetic, 1/2 per cent pontocaine hydrochloride, two times at about two minute intervals. Most superficial foreign bodies can then be removed with a wet cotton applicator. It is best to use the wet applicator in order to prevent the lint from dry cotton from abrading the cornea. One should always search the upper cul-de-sac for hidden foreign particles in that area. The lid retractor may be reversed, placing it upon the upper lid, turning the tarsal plate over the mar-

* Chairman's Address.
Read before the Seventy-eighth Annual Session, Arkansas Medical Society, Fort Smith, April 20, 1954.

gin of the retractor and, in most cases, a good view of the upper cul-de-sac can be obtained. If the foreign particle is embedded in the cornea, this of course requires the use of the slit lamp and a sharp eye spud. After the removal of an embedded particle, sterile homatropine should be instilled to dilate the pupil. A patch should be placed on the eye for at least eight hours and the patient given some form of systemic medication to control pain. It is much better to give systemic medication for pain rather than local application as it has been proven that local anesthetics retard healing to some extent. If there is accompanying conjunctivitis, or if the embedded particle has been present for over a period of 24 hours, it is usually wise to give some local antibiotic to be instilled at intervals of two or three hours. The patient should be seen in 24 hours to be sure there are no complications which might cause partial permanent disability.

Intraocular Foreign Bodies

Any patient with an intraocular foreign body should be put at complete rest immediately, with both eyes closed. If there is any question on the part of the examiner as to whether or not an intraocular foreign body exists, then x-ray should be made. If the x-ray is negative, another search must be made with the slit lamp and ophthalmoscope to attempt to find the intraocular particle. The electric magnet may be placed in front of the anterior segment of the eye as this, many times, produces a movement in the area of the iris, localizing the intraocular metallic particle. If an intraocular foreign body is found on x-ray, the next step is an accurate localization. There are many methods used and each ophthalmologist has his method of choice. The patient, of course, should be hospitalized and given antibiotics and tetanus antitoxin. The method of removal depends upon the material, the speed of entrance, location and trauma. This is not an emergency measure. It is better to get accurate localization and make adequate preparations but the delay should not be long enough to allow fibrin and vitreous to coagulate around the foreign material. The success of intraocular foreign body removal is: (1) Protection against infection; (2) good localization; (3) surgical skill.

Burns

Burns of the eye are the second most serious hazard to sight. Chemical burns are usually divided into alkali burns and acid burns. Severe alkali burns produce coagulation necrosis, secondary fibrosis of the cornea and, if severe, it goes on to secondary glaucoma and destruction. In any chemical burn irrigation and debridement are the most important part of the treatment routine. Mydriatics should be used to prevent secondary iritis and iris adhesions. Antibiotics should be used systemically and locally to prevent infection. Mucous membrane grafts may be required in the treatment of complications from such injuries.

Acid burns may be severe but the damage is usually done immediately and the end result is quickly ascertained. The same routine as used with alkali burns should be followed. There is some disagreement as to the value of neutralizing solutions. Some of the most prominent ophthalmologists do not believe neutralizing solutions should be used; others prefer the use of 5 per cent neutral ammonium tartrate or 5 per cent ammonium chloride for alkali burns and 3 per cent sodium bicarbonate solution for acid burns. Following a severe burn, soft adhesions begin to form and the use of the glass rod in the upper and lower cul-de-sac will help prevent formation of these adhesions. Cortisone may be used locally to decrease inflammatory reaction and opacities of the cornea and beta irridation may be used to destroy the limbus vessels as they cross to enter the corneal substance in their attempt to repair injured tissue.

Lacerations of the Cornea

Clean lacerations or slicing injuries of the cornea may be repaired by suturing the lips of the corneal wound. The conjunctival flap was formerly the most popular method of repairing such an injury. Using the Grieshaber needle on a 6-0 chromic suture to repair the wound results in much less reaction than the conjunctival flap. Blunt injuries to the anterior segment of the eye which rupture Descement's membrane result in more scarring of the corneal tissue. If there has been an iris prolapse the iris should be dressed inside the cornea with the spatula, the cornea repaired and the air injected into the anterior chamber to prevent the formation of anterior adhesions. In any perforating injury to the anterior segment of the eye there is always the problem of making a decision as to the necessity of an immediate enucleation. With the use of cortisone and antibiotics to reduce the inflammatory reaction, the treatment is now more conservative. If the injury extends into the ciliary body the eye is usually lost.

Contusions

A contusion of the eyeball may produce contrecoup retinal damage; it may cause a partial or complete subluxation of the crystalline lens; a scleral rupture, retinal and choroidal hemorrhages

or a traumatic cataract. We believe that a subluxated lens should be left alone unless the constant movement of the lens causes pain. It is not uncommon to see an employee with such an injury perfectly at ease while at rest, the eye becoming painful when he starts any movement. Such a lens usually has to be removed in order for the patient to be able to return to work.

Malingering and Evaluating Disability

Your State Industrial Compensation Commission will advise you that the formula for establishing partial permanent disability as result of an eye injury is that established by the House of Delegates of the American Medical Association May 26, 1926. This formula rates disability on the basis of loss of visual efficiency and takes into consideration visual acuity, visual fields and muscle function.

The problem of detecting and exposing malingerers is assuming ascending importance in this age of rapid socialization and care from "cradle to the grave." In the shirking of personal responsibility with increasing benefits to the unemployed, to the sick, to the disabled, to the indigent and aged, it has become more profitable not to work than ever before.

The problem of malingering has far reaching social and economic implications and as it often presents itself to the ophthalmologist, it is as difficult as it is distasteful. Some of the more popular and accurate methods of determining malingerers are: the high plus lens, blurring one eye for distance and, by the same token, the near vision being improved at the near point; the base out prism test and the red-green projection chart. The use of American Optical Company's polarized slide and polaroid glasses is very popular. For cases simulating more marked blindness, the Worth four dot test is useful and if total bilateral blindness is claimed the patient may be shadowed.

Everyone has his favorite method of detection. Studying the patient psychologically is of utmost value as it has been emphasized by Kleckner in his article entitled, "Malingering in Relation to Visual Acuity." Should our tests prove the patient is malingering, it still remains to be proven whether the deceit is intentional or whether it is produced by subconscious motivation. A knowledge of the patient's personality is essential if we make an accurate differentiation and avoid the embarrassment of false accusation. Our experience has been that it is usually the patient below the average in intelligence who has been ill advised and this type patient usually proves to be of no particular problem. There is, of course, the exception and that is the intelligent, malicious individual who proves to be a headache for all concerned.

While anyone with an injured eye is anxious to know what happened to his eye and what to expect, it is well in talking to such victims of industrial accidents, to be conservative in making positive predictions. Nature often comes to the rescue of man, accomplishing miracles of recovery. It is thought that in many cases severely injured eyes have been too hastily removed. Eyes which on initial examination appear to be lost, have been saved with enough sight to have protective vision.

Davidson has laid down the following principles which, if followed meticulously, would prevent the source of many medico-legal controversies:

(1) An originally wrong diagnosis where a traumatic condition has been mistaken for disease, or vice-versa.

(a) Luetic optic atrophy confused with optic atrophy of head injuries.

(b) Traumatic cataract confused with senile cataract.

(c) Traumatic ophthalmoplegia confused with hetrophories.

(2) A correct diagnosis but misjudged age of lesion.

Such a source of controversy arises primarily because of a delay by the claimant, or carrier, in securing medical attention.

(a) Time element between a retinal tear and detachment.

(b) Time element in pigmentation or corneal scars or fundus lesions.

(3) Diagnosis and age correct but relation to accident doubted. This controversy may arise because of discrepancy between the violence of the force of the accident and the result as found on examination.

(4) The bona fide pre-existence of diseases. It is dealing with this difficulty that the absence of pre-employment eye examination proves to be a great handicap. A disease may have existed prior to the injury, or the injury may have aggravated the disease. A decision has to be made as to what proportion belongs to each.

In the State of New York, industrial accidents to the eyes cost twice as much per injury as do other injuries and give rise to relatively double the number of controversies. This is true in varying degrees elsewhere and the ophthalmologists must learn to give time and attention to the first examination of an injured worker, to seek pathology and, if it exists, to find it. He should not

allow himself to overlook any pathology in an injured worker's eye. This is true irrespective of whether the pathology does or does not play a part in the injury that was sustained. We are all too familiar with the fact that the very case with the incomplete history and some undiagnosed pathology is the one that will eventually require your time and effort in an attempt to settle the controversy at the Compensation Commission, or in some higher court.

The best interests of management, insurance carriers, employees and the doctor are most effectively served by paying strict attention to the real nature of the problem as brought to us by our worker patient.

BIBLIOGRAPHY

Kuhn, H. G.: Industrial Ophthalmology, St. Louis, Mosby 1944, Chap. V.

Kleckner, J. F.: Malingering in Relation to Visual Acuity, Am. J. Ophth., 35:47, 1952.

Kuhn, H. G.: Personal Communication.

THE OUTLOOK FOR MAN

R. B. ROBINS, M.D., Camden, Arkansas

Senator Fagan, Governor Cherry, Dr. Evans, Dr. Dishongh, members of the National Association of Coroners, ladies and gentlemen:

First, I would like to express my appreciation to Dr. Dishongh and the officers of the National Association of Coroners for the honor of being your guest on this occasion. I have chosen as my title tonight a sociologic subject that should be of interest to all of us, "The Outlook for Man," i. e., fifty, one hundred, or five hundred years hence.

The development of atomic and hydrogen bombs has made it possible to annihilate the greater portion of humanity, but this is by no means the only danger confronting mankind. If our civilization is to survive, we must provide a long-range solution to the future problems of producing sufficient food for the ever-increasing world population and of furnishing sufficient energy for mechanical conversion of raw materials into consumable products. This is our moral debt to posterity; we cannot assume that we can muddle through somehow and miracles will happen.

The global revolution being waged today is, I believe, attributable to the increase in universal population. We are in the midst of a "breeding storm," the population of the world having more than doubled during the past one hundred years, to a present figure of around two and one-half billion. At the present rate, it will double again during the next twenty-five years. Despite casualties and emigration resulting from World War II, Europe's population continues to increase at an annual rate of approximately three million, with almost fifty million more people today than twenty-five years ago. Medicine's crusade against disease has resulted in the lowest mortality rate and, consequently, the highest birth rate in the history of the world, condemning millions to poverty eventually. The non-Caucasian population (the less privileged peoples) of the earth is already twice as large as the white, and it is continuing to multiply twice as rapidly. The energy or food intake of over 50 per cent of the world's population today is barely sufficient to maintain life. It is these underprivileged peoples who are staging a revolt of the masses—Communism on the march—the "something-for-nothing" ideology.

How will the ever-increasing needs of our world's constantly larger population be met? Despite tremendous pressures in the world to increase food supplies, the agricultural returns in the cultivated regions can barely meet existing demands—and often fail to. In 1951, the report of the Food and Agricultural Organization of the United Nations stated: "Most of those who were hungry in the five prewar years are now hungrier . . ." The quandary of Great Britain, Holland, and other European countries, whose lifelines to colonies rich in food and mineral surpluses have been severed, can be resolved only by readjustments in their standard of living.

Only five countries in the world today are capable of producing more food than their own people need: Australia, New Zealand, Canada, Argentina, and the United States. Australia, with a population today of eight and one-half million people, is said to have potential food production for forty million people. Its agricultural capacity, however, is limited by scarcity of natural water supply. New Zealand, whose total land area is equal only to that of Colorado, can hardly be looked upon as a major contributor to the world's food needs. Although Canada is a country of large potential, only 10 per cent of its land is suitable for agriculture, i. e., less than one-third

Annual banquet address, National Association of Coroners, Little Rock, Arkansas, August 18, 1954.

accepte

ACH

record time

ROMYCIN*

Hydrochloride
Tetracycline HCl Lederle

ACHROMYCIN, new broad-spectrum antibiotic, has set an unusual record for rapid acceptance by physicians throughout the country. Within a few months of its introduction, ACHROMYCIN is being widely used in private practice, hospitals and clinics. A number of successful clinical tests have now been completed and are being reported.

ACHROMYCIN has true broad-spectrum activity, effective against Gram-positive and Gram-negative organisms, as well as virus-like and mixed infections.

ACHROMYCIN has notable stability, provides prompt diffusion in body tissues and fluids.

ACHROMYCIN has the advantage of minimal side reactions.

LEDERLE LABORATORIES DIVISION AMERICAN Cyanamid COMPANY Pearl River, New York Lederle

*REG. U.S. PAT. OFF.

that available in the United States. Argentina, traditionally one of the world's greatest exporters of foodstuffs, exemplifies the strong modern trend to overemphasize industrialization at the expense of agriculture. And lastly, the United States, can it be considered a land of endless resources? Our population is increasing by around two and one-half million people each year, and it is estimated that by 1975 our population will require an additional one hundred and thirteen million acres more than are now in use, or seventy million more acres than envisioned in all presently projected government programs for land development and reclamation. Even improved technics cannot alone perform this miracle. Furthermore, we have by no means won the fight against soil erosion; the quality of our soils continues to deteriorate. Yet we still do not recognize protection of our agricultural base as the first need of a "national defense" program. We have not yet abandoned the fantasy that "America can feed the world."

The prevalent idea, especially in the United States, that industrialization in itself spells progress is fraught with danger. The velocity of industrial expansion within the present century has resulted in a terrific drain upon the earth's resources, consumption of wood, oil, coal, and a diversity of minerals having increased proportionately. In June 1952 the report of the President's Materials Policy Commission revealed that Americans, for instance, have used as much of the earth's riches in forty years as all the people the world over have used in four thousand years! The report prophesies that in the decade 1970-80 our present extensive usage of natural resources will be augmented by at least one-half, and we will have to depend upon the rest of the world for about one-fifth of all our requirements. Many resources are non-renewable and will eventually become exhausted. Thus, unless adequate and long-continuing supply of resources can be assured, industrialization must eventuate in ultimate failure. From a broad point of view, the primary answer to the world's pressing needs lies in widespread improvement and development of agricultural practices, including new sources of food supply.

What are the potentialities of the vast undeveloped regions of the earth? Whereas one-fifth of all the world's land surface lies within the bounds of Africa, one-third of this continent is desertland. Egypt itself, about as large as Texas and New Mexico combined, must sustain its twenty million people on a small area irrigated by the Nile, only slightly larger than Vermont. Africa has scarcely any metal industries, but it provides copper, manganese, chrome, tin, lead, zinc, iron, and cobalt to the industrial markets of Europe and North America. The Belgian Congo's mine is today the world's largest producer, and one of our country's principal sources, of high-grade uranium ore. Part of the task of the future is to assess the capacity of Africa for producing more food and fiber and for accommodating the unemployed and undernourished in other overcrowded countries. Although the great Amazon Valley would appear most provocative and challenging as a potential reserve, the conditions under which crops might be grown there commercially render the costs of production prohibitive. Moreover, the perennial inability of its natives to feed themselves is discouraging.

Population pressures in the inhabited regions in Asia, and especially in China and India, are so evident that these countries, containing almost two-fifths of all people of the world, have come to represent the extremities of suffering that result from overcrowding. Recently, Nehru in India had the National Congress pass a resolution encouraging family planning and establishment of birth control clinics. At some point in history, population growth must halt. We must become reconciled to the inescapable fact that artificial means of population control must be widely and wisely used, or we must resign ourselves to a future of worldwide starvation. We may avoid talking about it, moralists may lecture to the contrary, laws may forbid us to consider it, pressure groups may prevent political leaders from supporting it —yet the conclusion cannot be denied on any rational basis. Huge efforts have been directed toward improvement of public health in many developed areas, but the approach to the problem remains indirect. Since less frequent exposure to childbearing will yield lowered female mortality, smaller-sized families will permit improved nutrition and reduced infant mortality, and lower food requirements for individual families will effect generally diminished adult mortality, major birth control measures can justifiably be considered major public health projects and can thus rationally be given priority. Sweden, pioneering in this essential problem of human society, represents an experiment in population control. Its program is based on three principles: (1) that democracy implies voluntary parenthood and the right of the citizen to decide on the size of his family; (2) that the quality of the population should not be sacrificed for quantity; and (3) that the social and economic resources should be utilized to assure the maximum welfare for the maximum number of people.

Rapidly declining birth rates in two predominately Catholic countries—France and Italy—are evidence of increased conception control in spite of opposition of the church and illegality of the sale of contraceptives. That sexual restraint has played a significant role in lowering the birth rate in either country is extremely doubtful. In the past, religious laws have been molded in part by public attitudes and cultural pressures. The attitudes of the writers of Hebrew law toward birth control, for example, became altered with time as social forces changed. It is probable that, in the face of existing public opinion, Catholic dictum may become modified during future years. These changes cannot, however, be expected to evolve rapidly. If ecclesiastic resistance to family planning should suddenly cease, the course of population growth in many parts of the world might be drastically altered.

Several possible future courses have been advanced recently, including tapping of the immense reserves of organic material, both plant and animal, that exist in the ocean; manufacture of artificial foods; inducement of rainfall, and conversion of sea water to fresh water for irrigation of regions now too arid to bear crops; soil conditioners; new fertilizers; and so on. Any discussion of synthetic foods proper must, of course, deal at the outset with the common and all-pervasive prejudice that natural foods are more wholesome, tasty, and attractive than artificial foods. I cannot imagine you coroners tonight, for example, relishing a menu consisting of a capsule and listening to this speech with any degree of satisfaction.

In conclusion, I wish to re-emphasize the gravity of the rapidly approaching problem of inadequate food, minerals, and energy for the constantly increasing human numbers. At present, starvation is the only controlling factor. Perhaps one day new resources or new methods of providing essential resources may be found, but that day, at best, is far distant. Nuclear energy has little significance to the man whose body is starving. Conceivably, population control may be the eventual realistic approach to the solution of this problem, for as we look ahead today, it seems that we can see THE LIMITS OF THE EARTH.

BIBLIOGRAPHY

1. Brown, Harrison: The Challenge of Man's Future. The Viking Press, 1954.
2. Osborn, Fairfield: The Limits of the Earth. Little, Brown and Company, 1953.

OBITUARY

M. L. NORWOOD, 79, a practicing physician at Lockesburg for more than 50 years, died Oct. 7 at a hospital at Little Rock.

He was born at Paracliffta (Sevier County) January 12, 1875, and had lived here about 59 years. He was a 32d degree Mason and a Shriner and had served on the Lockesburg School Board 30 years.

Dr. Norwood was a member of the American and Southern Medical Associations, a charter member of the American Academy of General Practitioners and the Lockesburg Lions Club. He was president of the Arkansas Medical Society in 1916-17.

He was president of the Bank of Lockesburg and the Board of Stewards at the Methodist Church here.

Survivors include a son, a daughter, a brother, and a grandson.

Funeral services were held Sunday at the Methodist Church. Burial with Masonic services was at Lockesburg Cemetery.

EARLE H. HUNT, 68, Clarksville, died at the Clarksville Hospital after a few hours illness on November 16th. He had practiced medicine in Johnson County since 1909, and was a past president of the Arkansas Medical Society as well as delegate to the American Medical Association. He was a Fellow of the American College of Surgeons.

Dr. Hunt was a graduate of Tulane University, and attended many post-graduate seminars in various schools, keeping abreast of the medical times. He served on the State Board of Medical Examiners for a 6-year term, and was devoted to the various organizations of his profession.

He was a member of the Methodist Church and an active and colorful participant in many phases of the civic affairs of his community. He was always an active member in the Council meetings of the Arkansas Medical Society, and a leader in its deliberations.

Survivors are his wife, two daughters, a son, and seven grandchildren.

Burial was at Oaklawn Cemetery in Clarksville.

SAMUEL AUGUSTUS SOUTHALL, 87, a retired Lonoke physician, and one of the founders of the Arkansas Medical Society, died at his home.

He was the first president of the state Board of Health for 14 years.

After graduating from the University of Tennessee Medical School, he served his internship in the Memphis City Hospital, and worked in the city Health Department.

Dr. Southall moved to Lonoke County in 1901, and became a general practitioner. He served as county health officer for more than 20 years, and was a member of the Anatomy Board of the state Board of Embalmers for 10 years. During World War I he was civilian physician at Eberts Field near here.

A practicing physician for more than 50 years, Dr. Southall retired after World War II. He was a 32d degree Mason, a Shriner, and a life member of the Arkansas Medical Society.

He is survived by a son, a daughter, a brother, a sister, and three grandchildren.

The funeral was held at the Presbyterian Church in Lonoke. Burial was at Lonoke Cemetery.

S. M. WORTHINGTON, 86, retired Cabot physician, died in the home of his daughter 18 October 1954.

A native of Mississippi, he had practiced in and near Cabot for 50 years. Funeral services were conducted in the 1st Baptist Church. Burial was in Mt. Carmel Cemetery.

Notice has been received of the death of Thomas C. Douglass of Chicago after a short illness in October. A native of Ozark and a son of the late Dr. Thomas Douglass and Mrs. Douglass, he had made his home in Chicago for the past several years. He was a guest speaker at the April '54 meeting of the Arkansas Medical Society in Fort Smith.

C. K. CARUTHERS, 80, praticing physician for more than half a century, died in his home in Pine Bluff on October 21.

A native of Mississippi, Dr. Caruthers opened his office here in 1901 after graduating from the George Washington School of Medicine in St. Louis. He had remained active until a recent illness.

Survivors include his widow, four sons.

He was a member of the 1st Methodist Church and the Masonic Lodge.

Burial was in the Graceland Cemetery, Pine Bluff.

★ Editorial ★

ON LEADERSHIP

Our Arkansas Medical Society has, throughout its entire history, been among the foremost to resent the encroachment of Federal Government into the lives and rights of its people. We have furnished leadership on the theory that medical care is a local problem, and not a government problem. We are still in agreement with that conclusion. We can't agree with the Department of Health, Education and Welfare that every American has a "right" to free medicine. We believe that every American has the "right" to work and provide himself with the best medical care he can find. And he can find the best in the world within our own borders.

To set up her own medical care, Arkansas has furnished medical training within her own borders for some fifty years, and is planning and creating a superb medical school and hospital in keeping with the times. Our society has probably been the chief instrument in this progressive step.

There remains other leadership that it will be well to show. We read with some dismay of the formation of a "Health" committee in some of our counties, on which the physicians are completely absent. We believe this is accidental, and thoughtless. We also believe that it means the physicians in that vicinity have not impressed their people with their interest in public health and public affairs. Every health committee, whether formed by the Farm Bureau, the Women's Home Demonstration Clubs, or by any other group interested in the welfare of the community should have a physician from the County Medical Society among its members, and it goes without saying that he can be the source of much information and assistance in any or all problems that arise.

It is incumbent on any county medical society to furnish medical leadership in its area. The columns of this Journal have, at times been critical of the inaction of our own AMA, and if needs be, will continue to be so.

But we can't neglect the need for leadership to be furnished in our own smaller localities, and the county medical society must accept its responsibility and do a public service that is needed in its own community.

WHAT IS "FEDERAL" AID?

The simplest true answer is that it is money out of **your** pocket. This is also, in the long run, the only answer. The question is brought up when

we see organizations running to Washington for "help" in building this or that school, or hospital. It means, of course, that such organizations are admitting that they can't take care of the job themselves, or that they don't want to!

American medicine has been so restricted by "Federal Aid," and has stood up so long against a paternalistic government that **we hope for the day when no physician and no hospital will be asking alms at the Nation's Capitol.** Arkansas medicine has produced some of the leaders in the fight against "state" interference in the conduct of medical care, and will continue to do so. We believe that reminding our elected representatives that when such requests come in, from any state or any area, it means that such an area is asking for more than it needs or is unwilling to look after itself. Arkansas doctors don't need and don't want "Federal Aid."

MEMORIAL FOR FORMER LIBRARIAN

On October 20, 1954, Mrs. Elizabeth Richardson, Librarian of the University of Arkansas Medical School from 1928 until 1951, passed away following a long illness. Mrs. Richardson will long be remembered by her many friends in the medical world for her devotion to her work, her friendliness, her deep interest in the medical students and doctors, her sparkling and ready wit, and her gallant spirit which always fought on despite the odds. During the twenty-three years of her librarianship, the collection grew from one of a few thousand volumes to many thousand, due to her untiring efforts and in spite of the problems of inadequate space, limited funds and little or no help.

Contributions are being made by her friends at the Medical School and Hospital to a fund for the establishment of a suitable memorial to be placed in the Library. Friends interested in contributing any amount may send their contribution to Miss Florence Lawson, Dean's Office, School of Medicine.

MEDICAL ASSISTANTS ORGANIZE

A new organization associated with medicine came into being November 14th when the Arkansas State Medical Assistants' Society was organized. The organizational meeting was held at the Marion Hotel, Little Rock. The new society is sponsored by the Public Relations Committee of the Arkansas Medical Society, the Pulaski County Medical Society Public Relations Committee and the Pulaski County Medical Assistants Association.

With the help of Mrs. Elizabeth E. Peck, past president of the Michigan State Medical Assistants Society, a constitution was drawn up and adopted and officers elected to serve until the annual meeting in 1956.

Officers elected were: President, Miss Charleen Hardeman, Little Rock; President-Elect, Mr. Earl Swan, Dover; Recording Secretary, Mrs. Vivian Harris, Monticello; Corresponding Secretary, Mrs. Elizabeth D. Marsh, Little Rock; and Treasurer, Mrs. Mae Hardaway, Texarkana.

130 medical assistants registered for the meeting from 30 counties—representing all sections of the state. Plans were laid by those present to organize county medical assistants societies in every county with four or more medical assistants.

Only those persons employed in the office of a member of the Arkansas Medical Society, in medical hospitals licensed by the Arkansas State Board of Health, or in medical laboratories approved by the Arkansas State Board of Health are eligible for membership.

Through the organization, its members hope to become more useful members of the health team and its purposes are recommended to the members of the Arkansas Medical Society.

FROM WASHINGTON

Selective Service has launched its most extensive survey of medical manpower. Headquarters hopes to have on hand by December 1 the following important data: (1) total number of living registrants under the regular draft who are either physicians or dentists, (2) numbers in each regular Selective Service classification. Armed with this data, Selective Service will be prepared to answer questions expected to come from Congress when it takes up the extension of the regular draft and what to do about the Doctor Draft (both expire next June 30). The information also will help the Defense Department to decide how many of the approximately 1,325 physicians who will be completing their internships next June to defer for residencies (see LETTER No. 91). Officials are concerned that many non-veteran physicians have delayed joining the Defense Department's commissioning program on the theory that the Doctor Draft will be allowed to die and they will have no further obligation. Assuming that the regular draft will be extended, they will have a two-year obligation under the law, an obligation which must be served before their 35th birthday. Unless they sign up for a commission in one of the medical corps they might have to serve the two years as enlisted men, like other registrants. Congress has made clear that men brought in under the Doctor Draft are to be offered commissions, but this guarantee does not apply to the regular draft.

The Journal extends the greetings of the holiday season both Christmas and New Year's from the officers and Council of the Arkansas Medical Society. It is doubtful if there is a more devoted, and more unified group in organized medicine today, and as an organization consecrated to the improvement of health in our fellow man, it is one of the least selfish. The public of our state is indeed fortunate.

Arkansas TRAVELING

And Clipping Bits Here and There

WHAT EXCESSIVE GOVERNMENT SPENDING MEANS TO YOU

The nation's taxpayers had the wind taken out of their sails last week when the California Taxpayers Association reported that federal, state and local agencies will this year collect some 90 billion dollars in levies.

It's still quite difficult for the average taxpayer to fit himself into a statistic of such magnitude.

But the California association, a private research organization, discovered that it takes a $4,500-a-year man two hours and 35 minutes of his eight-hour day to earn enough to pay his taxes. The levies included are both direct and indirect.

Now this same $4,500 salaried man works only one hour and 37 minutes daily to pay for food for his family; one hour and 24 minutes for housing costs; 36 minutes for clothing and 42 minutes for transportation. He also labors 23 minutes for medical care, 20 minutes for recreation, and 23 minutes for other goods and services.

In other words, this typical person works only 26 minutes more a day to provide food and housing for his family than he does to pay his tax load.

The recent federal tax cut, the association said, helped him very little. He managed to save only a few minutes work time.

All of which points to the important need for more economy in government spending.

Secretary's Letter, A.M.A., Oct. '54.

Dr. W. Andrew Bunten, A.M.A. Delegate from Cheyenne, Wyoming—"When doctors of medicine realize that their best friends are the other physicians in their own communities, a great step forward will have been taken and many unnecessary situations, which result in ill feeling and misunderstanding, will have been eliminated. There is no greater incentive in the world for outstanding performance than good, clean, honest, and tough competition."

PROOF POSITIVE OF MEDICAL PROGRESS

The tempo of medical progress is reflected in the announcement that the Trudeau Sanatorium, the country's oldest private establishment for the treatment of tuberculosis, closed Dec. 1.

The New York Times said the 100-acre Adirondack cottage community, of Saranac Lake, thus "will yield to scientific progress in the treatment and cure of the disease that spurred its founding 70 years ago."

Dr. Gordon Meade, executive director, summed up the closing of the sanatorium in a few sentences:

"This is a milestone. We can no longer continue because of the decline in the number of tuberculosis patients. A patient's length of stay has been shortened by the new antibiotic drugs and surgery techniques; there have been fewer relapses and lots more home care."

The tuberculosis mortality rate has been dropping steadily. In 1900 the death rate was 200 per 100,000 population; today it is only 12.6 per 100,000.

ANNOUNCING 10th RURAL HEALTH MEETING

Be sure to add A.M.A.'s 10th National Rural Health Conference to your 1955 appointment book. The dates—February 24-26; the place—Schroeder Hotel, Milwaukee, Wis. Theme will be "Looking Both Ways" at such problems as accident prevention and family responsibility in health affairs.

As in past years, a special pre-conference session for members of the medical profession will be held Thursday morning, February 24. Discussions will be aired on the work of medical society rural health committees, responsibilities of citizenship and training for rural practice.

COMING EVENTS

ARKANSAS MEDICAL SOCIETY
Hot Springs, May 30 - June 1, 1955

NEW ORLEANS GRADUATE MEDICAL ASSEMBLY
March 7-10, 1955

UNIVERSITY OF TEXAS POST-GRADUATE SCHOOL OF MEDICINE
Temple, Texas, March 7-9, 1955

AMERICAN ACADEMY OF GENERAL PRACTICE
Los Angeles, March 28-31, 1955

TUBERCULOSIS ABSTRACTS

A Review for Physicians

ISSUED MONTHLY BY THE NATIONAL TUBERCULOSIS ASSOCIATION

BED REST IN THE TREATMENT OF TUBERCULOSIS

CHAIRMAN—Robert H. Ebert, M.D. COMMITTEE ON THERAPY, AMERICAN TRUDEAU SOCIETY—Robert L. Yeager, M.D., Robert A. Goodwin, M.D., Edward F. Parker, M.D., Carl Muschenheim, M.D., Paul T. Chapman, M.D., Morris C. Thomas, M.D., Roger Mitchell, M.D., Raymond F. Corpe, M.D.

A Statement by the Committee on Therapy of the American Trudeau Society,
The American Review of Tuberculosis, June, 1954.

The continuing reports showing the increased effectiveness of antimicrobial therapy in the treatment of pulmonary tuberculosis have caused many physicians to question the necessity or advisability of prolonged bed rest.

This has been further accentuated by the featured publication in newspapers and magazines of proposed clinical studies, although no such studies have in fact progressed to a stage which permits even preliminary conclusions to be drawn. Programs for the treatment of unhospitalized patients are frequently misnamed and misinterpreted as "ambulatory" treatment programs, as opposed to bed-care programs. In actuality, such programs are designed to supplement hospital care of patients, rather than to replace it by: (1) commencing antimicrobial therapy before hospitalization can be effected in communities where there is shortage of hospital beds; and, (2) continuing long-term drug therapy after control of the disease has been effected by hospital treatment. Even when home care is substituted entirely for hospital care by organized outpatient services, provision is made for bed care in the home. The designation of programs of this type as "ambulatory" presupposes an abandonment of the principle of rest therapy which is not intended and is not yet, at least, recommended by any official group.

The Committee again states that, from the facts now available, there is no evidence to support a reduction in the amount of rest therapy from that of past practices except as this may be justified by an earlier attainment of an inactive status of the disease. There appears to be no doubt that antimicrobial therapy has materially shortened the period of recovery in the average case of tuberculosis, and that it has greatly decreased the case mortality rate. This does not necessarily imply, however, that it has altered the indications for rest therapy during the active phases of the illness.

The studies which are in progress to determine to what extent bed rest may be safely dispensed with, or in what categories or stages of the disease it may play an unimportant role in therapy, will require a long period of study. Until these studies are completed, the clinician will be well advised to adhere to the established indications for bed care. Essentially, these consist of relatively complete bed rest in accordance with previously accepted principles, until all symptoms have cleared, all cavities have been lost to view roentgenographically, all regressive infiltrations have reached an unchanging status, and sputum or gastric washings have become negative for tubercle bacilli by direct examination and culture. From this stage, gradual physical rehabilitation by progressive mobilization of the patient is permitted and is usually so graded to restore him to relatively normal activities no sooner than in six to twelve months. The total period of disability, although greatly shortened on the average, must still be estimated even in relatively mild and favorably responding cases as a minimum of one year. Even after this, the usual protective restrictions as to character and hours of work and the avoidance of strenuous exertion or fatigue must be observed for at least several years. The continuation of antimicrobial therapy itself for a total of one and one-half to two years is commonly recommended, but information is not yet available with respect to whether this provides adequate protection to permit any shortening of the convalescent period.

The indications for rest therapy during the active phases of tuberculosis are not altered by the proposals that patients may subsequently be treated with either surgical collapse or resection. A preliminary period of bed rest, combined with

antimicrobial therapy, until all symptoms have cleared, cavities have diminished in size, or remain unchanged, and infiltrations have reached a relatively unchanging status is suggested. A continued period of rest after the surgical therapy is completed until it is evident that sputum or gastric washings will become and remain negative by culture and that the patient be symptom free should be used. From this stage, gradual physical rehabilitation for a period of several months, with the usual further protective restrictions, is indicated.

PERSONALS AND NEWS ITEMS

The Arkansas State Practical Nurses Association met in El Dorado November 4th through 7th. Physicians appearing on the program were:

David Yocum, El Dorado; Gardner H. Landers, El Dorado; Warren S. Riley, El Dorado; Earle Hunt, Clarksville; Garland D. Murphy, Jr., El Dorado.

R. B. Robins presided at the banquet November 5th.

Contributors to the American Medical Education Foundation during the month of October were: B. A. Bennett, R. H. Chappell, E. M. Gray, C. Lewis Hyatt, Robert F. Hyatt, Jr., and Sam G. Jameson

---

James W. Headstream and James T. Wortham presented a paper entitled "Bilateral Adrenalectomy in Diabetes with Degenerative Vascular Disease," at a meeting of the South Central Section of the American Urological Association in Colorado Springs October 18, 1954. The paper was discussed by William Balk, professor of Urology, University of Kansas School of Medicine.

For the coming year the University of Arkansas Medical Alumni Association has elected as its new officers: President—Alan Cazort of Little Rock, class of 1928; Vice-President—Tom Tyndall of Beaumont Texas, class of 1942; and Secretary-Treasurer—H. A. "Ted" Bailey of Little Rock, class of 1947.

Attending the Oklahoma City Clinical Society's Annual Fall Conference October 25th and 26th were: W. A. Fowler, Fayetteville; Thomas G. Johnston, Little Rock; L. A. Whittaker, Fort Smith; Cal D. Gunter, Siloam Springs; J. J. Monfort, Batesville; and W. L. Shippey, Fort Smith.

Lee Smith opened an office in Mineral Springs Oct. 11 for a general practice. He returns to his native state from an internship in Letterman General Hospital, San Francisco, and some further work in St. Jospeh, Mo.

J. W. Walker is now located at Tuckerman. He has been in Memphis, and had a general practice in Hayti, Mo.

The city of Stuttgart will vote this fall on a new hospital to replace the Drennan Hospital which closed in November.

Louis K. Hundley, Pine Bluff, addressed the 6th Annual Public Health meeting in Little Rock Oct. 27. He spoke on "The Private Physician Views Public Health."

The Arkansas Medical Directors Association elected officers at its annual meeting Oct. 29.

J. A. Summers was elected president and A. M. Mashburn was re-elected secretary. J. T. Herron was named a delegate to the National Association of Medical Health Officers. All are from Little Rock.

Conway voted Dec. 6 on the bond issue of a new $600,000 hospital.

Crossett named W. A. Regnier its "Good Citizen" in October.

W. M. Douglas opened offices in November. A native of Sheridan, he went to Jonesboro following a two-year stint with the Navy and a year's surgical training in Evansville, Indiana.

George F. Lull, secretary manager of the American Medical Association addressed the student body of the School of Medicine in Little Rock on November 11.

Clark County Medical Society adopted the initiative in observing Diabetes Week in Arkadelphia, November 14-20. President P. R. Anderson announced that H. D. Luck was chairman for the drive and all Clark County physicians cooperated.

The Third Councillor district elected M. L. Dalton, Brinkley, president. Milton John, Stuttgart, vice-president, and J. P. Williams, Brinkley, secretary.

Fire destroyed the office of Robert L. McDonald, Eudora, early in November and damaged considerable medical equipment. He is in temporary offices at present.

Jan Crow, formerly of Rison, and E. M. Barker, Jacksonville, are opening joint offices in the Jacksonville Hospital.

PROCEEDINGS OF SOCIETIES

Ninth Councilor District meets in Harrison December 3.

The program is in charge of the secretary, Ross Fowler, Harrison.—G. H. Butler, President.

The Fifth Councilor District met in Camden November 11 for a dinner meeting. George F. Lull, secretary-manager of the American Medical Association, and W. R. Brooksher, president of the Arkansas Medical Society, were guest speakers.—Paul Sizemore, Secretary.

At the October 22-23 meeting of the Arkansas Obstetrical and Gynecological Society in Little Rock members of the same organization in Memphis-Shelby County and in Mississippi were guests for the two-day session.

Members taking part in the program include President Charles P. Wickard, C. G. Sutherland, Clark Gillespie, Little Rock; John W. Jones, Texarkana, and Calvin R. Simmons, Pine Bluff.

J. F. Kelsey, Secretary.

Willard Pruitt and J. P. Thompson entertained the Ouachita County Medical Society at dinner in Camden Thursday night, October 7.

A symposium on Cortisone and ACTH was conducted by W. G. Cooper and Drew Agar of Little Rock—R. B. Robins, Secretary.

The Craighead-Poinsett County Medical Society met October 6th at the Hotel Noble in Jonesboro with 35 members present. Dr. W. W. Burpeau, pathologist at St. Joseph's Hospital in Memphis, spoke on "Hyatid Mole," followed by discussion on cases reported by Paul Ledbetter and Grover D. Poole.

The Pope-Yell County Medical Society met at St. Mary's Hospital, Thursday, November 11, 1954.

Richard V. Ebert, professor and head of Department of Medicine at the University of Arkansas was the guest speaker. He spoke on "Prevention and Treatment of Rheumatic Heart Disease."

W. E. King, M.D., Secretary.

The Craighead-Poinsett County Medical Society met November 3rd at the Hotel Noble in Jonesboro. Gwyn S. Robbins, of Memphis spoke on "Recent Advance in Chest Surgery," followed by Fontaine B. Moore of Memphis who talked on "Urologic Problems in Pregnancy and Treatment of Acute Anuria."—J. H. McCurry, M.D., Sec'y.

The Regional A.P.A. Research meeting will be held in Galveston on February 18 and 19, 1955. The theme of the meeting will be "The Physiologic Basis, Values, Limitations, and Hazards of Pharmacologic Products Recently Introduced in the Treatment of Psychiatric Disorders." Members of the A.P.A. and others interested in this topic and interested in presenting papers at this meeting are requested to contact Dr. Martin L. Towler, 112 North Boulevard, Galveston, Texas.

The **Third Councilor Medical Society** held its quarterly meeting at Brinkley October 28. Marion S. Craig, Henry Hollenberg, and James Headstream, Little Rock, and Pervis Minor of Memphis, furnished the program.

The fall meeting of The Arkansas Obstetrical and Gynecological Society was held in Little Rock on Oct. 22 and 23, 1954, with the Memphis and Mississippi Societies as guests. There were 75 in attendance. Jason H. Collins, assistant professor, Obstetrics and Gynecology, Tulane University School of Medicine, New Orleans, Louisiana, presented papers on "The Use of Tracheotomy in Eclampsia" and "Cul-de-centesis As An Aid in Gynecology." James R. Reinberger, professor, Obstetrics and Gynecology, University of Tennessee College of Medicine, Memphis, Tennessee, discussed "Hysterectomies in Memphis Private Hospitals" and Harold Feinstein, instructor, Obstetrics and Gynecology, University of Tennessee College of Medicine, Memphis, Tennessee, presented a paper on "Functional Uterine Bleeding." The remainder of the program was presented by members of the Arkansas Society and Residents from The University of Arkansas School of Medicine and Tulane University.

J. F. Kelsey, Secretary.

The three-day symposium in Industrial Medicine and Surgery held in October, registered thirty-seven physicians for the course which was put on primarily by the faculty of the University of Arkansas School of Medicine, according to N. B. Daniel, Texarkana, chairman. This is the first such program and its reception was such that the committee, a standing group from The Arkansas Medical Society is planning to make it an annual event.

Alumni of the Medical School in Little Rock organized a Post-Graduate Program for the last week in October at Little Rock. There was excellent response and further plans along that line are being considered for two meetings next year.

CONGRESSMAN MILLS HONORED

The Second District Medical Society met in Searcy October 18 at which the Honorable Wilbur D. Mills, member of Congress, was the featured guest at a luncheon. Society President W. R. Brooksher, Ft. Smith, was the chief speaker.

The annual meeting of the Arkansas Chapter of the American College of Surgeons was on October 14, 1954, in Little Rock. Thirty-six members and seven guests attended.

The program consisted of ten interesting papers by the membership.

The following officers were elected for 1955: President, Roy I. Millard, Russellville; Vice-President and Secretary-Treasurer, Peter O. Thomas, Little Rock.

A cocktail party for members, guests and their wives followed.—Peter O. Thomas, Secretary.

BOOK REVIEWS

Lectures on General Pathology: Delivered at the Sir William Dunn School of Pathology, University of Oxford. Edited by Sir Howard Florey, Professor of Pathology. Illustrated. Pp. 733. 1954. $13.00. W. B. Saunders Company, Philadelphia.

This collection of Pathology lectures represents the advanced thinking of a number of good pathologists, biochemists, and a few others. They cover separate fields and are painstakingly up to date. The editor, Dr. Folsey, has selected them for a text which some polished pathologists will find as stimulating and as modern as will the average physician reader. While every lecture will not appeal to each physician, it is doubtful if any 3rd or 4th year medical student or any practitioner could put the book down without finding a few of its papers especially interesting to him. This book is recommended for a library where many physicians can use its many and varied papers.

Diseases of the Skin: George Clinton Andrews, M.D., F.A.C.P., Clinical Professor of Dermatology, the College of Physicians and Surgeons, Columbia University; Attending Dermatologist to the Presbyterian Hospital, Columbia-Presbyterian Medical Center, New York. September, 1954. Fourth Edition. Pp. 877. Illustration 777. W. B. Saunders Company, Philadelphia. Price $13.00.

This classical text has been popular for three editions and this 4th edition is a worthy successor. Interestingly enough, a comparison of the various chapters in the first and fourth editions shows that the next text is up to date. Syphilis of the skin started with more than 100 pages, and in the new text, with Yaws and Pinta added, occupies less than forty pages.

The general form of the book is modified to some extent. Early chapters on the basics, Anatomy and Pathology, have been condensed into one chapter and more space has been given to the physical elements in the treatment, radium and roentgen-ray.

The revision has been done with meticulous care and precision. It remains a text of Dermatology which is up to date and yet holds the same charm of directness and simplicity which has made it a best seller through these four editions.

Uses of Wine in Medical Practice: A summary. Wine Advisory Board of California, San Francisco 3, 1954.

This brochure is, as indicated, a summary of the medical aspects of wine, its preparation and chemical constituents. The bibliography is extensive, but does not include the classical one attributed to St. Paul. The booklet is available without cost to physicians, on request at the address given above.

The Scourge of the Swastika: A Short History of Nazi War Crimes: Lord Russell, C.B.E., M.C., Liverpool. Pp. 259, 16 illustrations. $4.50.

A study of the brutality of man as carried on by the Gestapo in Germany under the guise of "state socialism," which is the spawning grounds for such dictatorships. This volume documents the cruelty of mental perverts over a will remind us of the appalling crimes that can be com-
will remind us of the appaling crimes that can be com-
mitted when socialism and its attendant control takes over a government.

The author felt that the documentation of these Nazi war crimes was of such importance that he was compelled to resign from the post of Judge Advocate General of the Forces in London, because of his refusal to drop publication of this book.

Pediatrics: Waldo E. Nelson, M.D., Editor, Professor of Pediatrics, Temple University, School of Medicine, Medical Director of St. Christopher's Hospital for Children. Pp. 1581. 440 Illustrations. Sixth Edition. W. B. Saunders Company, Philadelphia, 1954. $15.00.

This new edition of a familiar pediatric textbook is, as usual, an excellent reference and guide in the care of both the healthy and the ill infant and child.

Considerable revision of many of the sections has been made in accord with current pediatric trends. The list of contributors to this volume is impressive. A number of these chapters have been entirely rewritten. Comment is made on the early feeding of solids in infants, but these authors go along with the older accepted feeding formulas. The chapters on the use of antibiotics are completely revised and refreshed.

This standard text will continue to prove its usefulness in the future as in the past, an exhaustive study and a complete work of reference—with a comprehensive bibliography. Every practitioner who sees pediatric patients would do well to have this volume in his library.—J.R.D.

U. C. MEDICAL CENTER LIBRARY
JAN 24 1955
San Francisco, 22

JANUARY 1955

THE JOURNAL OF THE ARKANSAS MEDICAL SOCIETY

VOL. LI No. 8

FORT SMITH, ARKANSAS

79th ANNUAL SESSION ARKANSAS MEDICAL SOCIETY
HOT SPRINGS, MAY 30, 31 - JUNE 1, 1955

Easy to give . . . and to take

ILOTYCIN DROPS

(Erythromycin, Lilly) Ethyl Carbonate

Unexcelled antibiotic spectrum—notably safe
Meets the exacting demands of
Physician—Mother—Baby

Lilly **Another reason to**

for the epilepti

Modern diagnostic methods and effective anticonvulsants now help the patient with epilepsy enjoy greater freedom from seizures. And with a more understanding society, greater independence is assured.

DILANTIN® SODIUM (diphenylhydantoin sodium, Parke-Davis)

an established anticonvulsant of choice, alone or in combination, for control of grand mal and psychomotor seizures -- without the handicap of somnolence.

DILANTIN Sodium is supplied in a variety of forms -- including Kapseals® of 0.03 Gm. (½ gr.) and 0.1 Gm. (1½ gr.) in bottles of 100 and 1,000.

reater independence

MEDICAMENTA VERA
PD & CO.
Parke, Davis & Company
DETROIT, MICHIGAN

THE

Journal

OF THE

Arkansas Medical Society

Owned by

THE ARKANSAS MEDICAL SOCIETY

And Published Under Direction of the Council

FOUNT RICHARDSON, M.D., Editor

316 West Dickson Street — Fayetteville, Arkansas

MR. PAUL C. SCHAEFER, Business Manager

215 Kelley Bldg. — Fort Smith, Arkansas

The Advertising policy of this JOURNAL *is governed by the rules of the Council on Pharmacy and Chemistry of the American Medical Association.*

EXCLUSIVE PUBLICATION—Articles are accepted for publication on the conditions that they are contributed solely to this JOURNAL.

COPYRIGHT, 1955—By The JOURNAL *of the Arkansas Medical Society.*

NEWS—Our readers are requested to send in items of news, also marked copies of newspapers containing matter of interest to the membership.

OFFICERS OF THE ARKANSAS MEDICAL SOCIETY

W. R. BROOKSHER, President....Fort Smith
L. H. McDANIEL, President-Elect....Tyronza
T. P. FOLTZ, First Vice-President....Fort Smith
ELDON FAIRLEY, Second Vice-President....Wilson
R. H. WHITEHEAD, SR., Third Vice-President....DeWitt
J. J. MONFORT, Secretary....Batesville
DANIEL H. AUTRY, Treasurer....Little Rock
T. DUEL BROWN, Speaker, House of Delegates....Little Rock
C. C. LONG, Vice-Speaker....Ozark
MR. PAUL C. SCHAEFER, Executive Secretary
215 Kelley Bldg., Fort Smith

COUNCILORS

First District—JOE VERSER....Harrisburg
Second District—HUGH R. EDWARDS....Searcy
Third District—J. MAX ROY....Forrest City
Fourth District—L. K. HUNDLEY, Chairman....Pine Bluff
Fifth District—D. E. WHITE....El Dorado
Sixth District—HARRY E. MURRY....Texarkana
Seventh District—H. KING WADE, JR....Hot Springs
Eighth District—H. ELVIN SHUFFIELD....Little Rock
Ninth District—FOUNT RICHARDSON....Fayetteville
Tenth District—J. M. KOLB....Clarksville

VICE-COUNCILORS

First District—WAYNE WORKMAN....Blytheville
Second District—JOHN SNEED....Conway
Third District—J. P. WILLIAMS, JR....Brinkley
Fourth District—H. W. THOMAS....Dermott
Fifth District—GEORGE BURTON....El Dorado
Sixth District—CHARLES YARBOROUGH....Texarkana
Seventh District—RANDOLPH ELLIS....Malvern
Eighth District—ROBERT D. JONES....Little Rock
Ninth District—LEE A. DEAN....Rogers
Tenth District—LOUIE A. WHITTAKER....Fort Smith

Notice on Form 3578-P to be sent to the Arkansas Medical Society, 215 Kelley Building, Fort Smith, Arkansas. Published monthly under direction of the Council, Arkansas Medical Society, at Fort Smith, Arkansas. Vol. 11, No. 8. Subscription $3.00 a year. Single copies 50 cents. Entered as second-class matter, Sept. 23, 1947, at the post office at Fort Smith, Arkansas, under the Act of Congress of March, 1879. Acceptance for mailing at special rate of postage provided for in Section 1103, Act of October 3, 1917, authorized August 1, 1918.

• SPECIAL FEATURES

Committee on Cancer Control.... 173

Pelvic Tumors with Ascites and Hydrothorax.... 174

The Management of the Acute Severely Involved Poliomyelitis Patient.... 176

The Use of Cortisone During Pregnancy.... 180

• FEATURES

Editorial.... 185

Tuberculosis Abstracts.... 187

Obituary.... 188

Arkansas Traveling.... 190

Personal and News Items.... 191

Proceedings of Societies.... 193

Woman's Auxiliary.... 194

Book Reviews.... 194

Preliminary Program.... 199

The JOURNAL
OF THE ARKANSAS MEDICAL SOCIETY
PUBLISHED MONTHLY UNDER DIRECTION OF THE COUNCIL

Vol. LI January, 1955 No. 8

Committee on Cancer Control

C. A. ARCHER, Chairman, Conway

CANCER OF THE LUNG

C. A. ARCHER, Chairman

Unusual publicity given cancer of the lung in recent months has been productive of much discussion, both lay and professional. Theories implicating cigarette smoking and air pollution have been expounded in much detail. The information available, while most suggestive, is certainly not sufficient at this time for positive conclusions.

There is general acceptance that pulmonary resection is the preferred treatment, but it offers success only in the early, limited case. This emphasizes the urgent need that the disease be recognized in its initial stage. The inclusion of a chest roentgenogram as a routine part of the general physical examination in patients over forty years, especially males, seems warranted. Case-finding by mass survey procedures and by general hospital admission chest X-ray examinations should detect lung malignancies in an appreciable number of cases.

PELVIC TUMORS WITH ASCITES AND HYDROTHORAX

REPORT OF A CASE

RUTH ELLIS LESH, M.D., F.A.C.S.
Fayetteville, Arkansas

Meigs in 1934 in **Tumors of the Female Pelvic Organs** gave the first modern description of fibroma of the ovary with ascites and hydrothorax. This was followed in 1937 with a report by Meigs and Cass of 7 cases of fibroma of the ovary with hydrothorax and ascites which were cured by removal of the fibroma. Thereafter, the condition became known as Meigs' Syndrome although Demons of Bourdeaux, France, in 1887 had reported that 9 of 50 patients with ovarian cysts accompanied with fluid in abdominal and chest cavities had been cured by removal of the cyst, and later reported cases of the true syndrome with the ovarian tumors being fibromas.

In two recent comprehensive papers Meigs discusses the occurrence of ovarian tumors with fluid in the abdominal and chest cavities. He re-defines the syndrome as described by him, and also discusses malignant and benign cystic conditions of the ovary accompanied by ascites and hydrothorax. The true syndrome must meet four criteria: (1) there must be a fibroma-like benign tumor of the ovary (including thecomas, granulosa cell, and Brenner tumors), (2) there must be fluid in the abdomen, (3) fluid must be in the chest, and (4) the fluid must disappear with removal of the tumor and not recur.

Meigs' syndrome is usually seen between the ages of 40 to 60. The symptoms are not pathognomonic but usually consist of abdominal swelling, dyspnea, loss of weight, sometimes abdominal and/or chest pains, and edema of the legs. The patient is often cachectic. When a hard tumor of the ovary can be palpated, the diagnosis can be made. The abdominal and chest fluids are usually straw colored, but may be blood tinged. The right chest is more often the site of the hydrothorax, though the reason for this is not yet apparent. The left chest may be involved or the fluid may be bilateral. The mechanism of the presence of the chest fluid is presumptive, although rather plausibly explained. The fluid in chest and abdomen is similar. The specific gravity is below 1.015 which is typical of a transudate. The fluid is usually sterile on culture, and in the more recent cases, Papanicolaou smears show no malignant cells. The fluid has a low protein content and there is a predominance of lymphocytes and mononuclear cells. Other laboratory procedures show no typical findings. It has been fairly definitely proven that the current of the fluid is from abdomen to chest. Meigs and others have recovered from the chest India ink particles which were injected into the abdomen. There must be some here-to-fore unexplained passage between the two cavities, either through the diaphragmatic lymphatics or the interstices of the diaphragmatic cells.

The origin of the abdominal fluid thus becomes most important. A secretion from the fibroma itself probably accounts for the ascitic fluid. Most of these tumors show evidence of edema within themselves, the cause of which is undetermined. Meigs postulates that "pressure of the hard structure on the lymphatics in the tumor itself causes the escape of fluid through the surface lymphatics that are situated just beneath the single-layered cuboidal epithelium covering the tumor." Thus the fluid in the abdomen may be a result of seepage from the tumor lymphatics due to pressure. This mode of formation of the fluid is only probable because not all fibromas result in ascites (this is variously given as between 1 and 70% with an average of 40%) just as not all fibromas with ascites have fluid in the chest. The fibromas with ascites show cystic changes in the center which through pressure probably cause further edema.

The treatment of the condition is by simple removal of the tumor. Thoracentesis or paracentesis is useless as the fluid rapidly re-accumulates without surgery. These procedures are also actually unnecessary, as the fluid rapidly disappears following removal of the tumor.

Besides the problem that not all fibromas are accompanied by fluid, the malignant ovarian tumor which meets Meigs' specifications of hydrothorax, ascites, and cure following removal of the tumor, must be placed in some category to avoid confusion with the typical Meigs' syndrome. These cases might even be included in his syndrome if no pleural or abdominal metastatic lesions exist. Meigs lists 14 malignant tumors with hydrothorax and ascites, some of which were cured by removal of the tumor alone, but he does not classify these as Meigs' syndrome.

Presented: Arkansas Chapter American College of Surgeons, Little Rock, October 15, 1954.

Fig. 1. Chest film prior to admission to hospital, 1942.

The following report adds one more case to the malignant group of ovarian cysts with chest and abdominal fluid with recovery following removal of the cyst. The patient is in apparent good health 12 years following surgery.

This patient, Mrs. G. K., white, age 44, was admitted to Fayetteville City Hospital on February 27, 1942. She had presented herself in the office the previous day complaining of "fullness in the abdomen and bloating," but there was no pain. She had lost twelve pounds in the past two months. The patient stated that she had been conscious of an abdominal tumor mass for five years, but had sought no treatment until the present time. Onset of menses was 13 years, regular, with a 28-day interval, lasting 2-5 days. The patient had six pregnancies with normal deliveries, and no miscarriages. The oldest child was 22 years of age and the youngest 12 years. The family history was not pertinent except that three maternal aunts had tuberculosis, and the maternal grandmother had cancer—site unknown.

Upon examination the patient was found to have a large ovarian cyst which practically filled the abdominal cavity. There was fluid in the right chest. The patient was cachectic and markedly anemic. No elevation of temperature was present.

Following admission to the hospital four transfusions of whole blood were administered. Coincident with the first three transfusions the patient had a chill and a febrile reaction. On February 29, 1942, a thoracentesis was performed and 1800cc of straw-colored fluid was obtained. Culture of the fluid showed no growth. On March 1, thoracentesis was again performed with withdrawal of 2000cc of fluid. 1300cc were removed from the chest on March 3, and 2000cc removed on March 5. No Papanicolaou smears were made at that time. On March 10, the patient was taken to surgery, and under a spinal anesthesia a bilateral salpingo-oophorectomy was performed. There was free, straw-colored fluid in the abdominal cavity. The right ovary was enlarged irregularly and practically filled the abdominal cavity. When the cyst was opened it contained clear fluid and many polypoid growths. There was a cyst about the size of a small orange replacing the left ovary. No other pathology was noted, and there were no peritoneal implants present. The patient stood the operative procedure well, and made an uneventful postoperative recovery. The fluid in the chest was rapidly absorbed following surgery. The patient gained weight rapidly, and soon returned to her usual duties.

A chest plate October 8, 1948, showed no pathology, and the patient is well at the present time.

The pathological studies showed the tumor to be a malignant adenoma or a papillary adenocarcinoma of the ovary. There was great variation in the morphology of the epithelium, the

Fig. 2. Chest film six years following surgery, 1948.

cells varying from tall columnar to large oval and cuboid cells with deeply staining nuclei.

The above case is reported in order to call attention to patients with ascites and hydrothorax, whether associated with benign fibromas or malignant cysts, who can be cured by simple excision of the tumor. Operative procedures may be carried out on patients otherwise considered inoperable.

I wish to thank Dr. Loyce Hathcock for the use of the initial chest film.

REFERENCES

1. Calmenson, M., et al:: Surg., Gynec. & Obst. 84:181, 1947.
2. Conway-Hughes, J. H. L.: Brit. J. Radiol. 24:223, 1951.
3. Meigs, J. V.: Am. J. Obst. & Gynec. 67:962, 1954.
4. Meigs, J. V.: Ob. & Gynec. 3:471, 1954.
5. Meigs, J. V.: Tumors of the Female Pelvic Organs, New York, 1934, The MacMillan Company.
6. Meigs, J. V. and Cass, J. W.: Am. J. Obst. & Gynec. 33:249, 1937.
7. Schench, S. B., & Eis, B. M.: Am. J. Obst. & Gynec. 38:327, 1939.
8. Simon, H. J.: Am. J. Obst. & Gynec. 53:1042, 1947.

THE MANAGEMENT OF THE ACUTE SEVERELY INVOLVED POLIOMYELITIS PATIENT

ROBERT R. JACKSON, M.D.*

The group of patients that one could consider to have serious involvement comprises some 34% of those individuals who have paralytic poliomyelitis. Even though it forms but a minor percentage of the overall incidence of the disease, it is, nevertheless, in this group that fatalities occur. Thus it is apparent that one should recognize serious involvement so that intensive efforts may be directed toward salvage of as many of these individuals so involved as is possible.

In a discussion of the management of a seriously involved poliomyelitis patient, we must first outline the categories that define serious involvement. This group of individuals is generally considered to have one or more of the following:

1. Respiratory muscle paralysis.
2. Bulbar signs, most importantly involvement of the nucleus ambiguous or the swallowing mechanism.
3. Disturbances of the central neural control of respiration and cardiac and vasomotor activity.
4. Airway obstruction based on, or accompanying, any of the above.

The major suggestive signs that serious involvement exists, or is incipient, may be summarized as follows:

1. History of (a) marked or unusual exertion during the prodromal phase and/or (b) rapid onset and progress of flaccid paralysis.
2. Presence of bulbar signs, especially those referable to the nucleous ambiguous.
3. Peripheral paralysis which involves the muscles of the shoulder girdle, and most particularly the deltoid.
4. General appearance of marked toxicity; especially:
   (a) prostration, apprehension or irritability,
   (b) marked temperature elevation,
   (c) florid facies and/or generalized erythematous appearance,
   (d) moderate to marked degrees of tachycardia,
   (e) moderate to marked degrees of hypertension,
   (f) nystagmus on far lateral gaze.

On the basis of degree these suggestive signs are confirmed, and the confirmatory signs may be summarized as follows:

1. Evidence of respiratory muscle paralysis.
2. Marked changes in the sensorium.
3. Swallowing difficulty.
4. Cutaneous mottling and cyanosis or blanching of the skin—grey pallor—sluggish skin circulation.
5. Extreme hyperthermia.
6. Cyanosis.
7. Myocardial failure.
8. Pulmonary edema.
9. Unconsciousness.

Read before the Seventy-eighth Annual Session, Arkansas Medical Society, Fort Smith, April, 1954.
*From the Departments of Pediatrics and Physiology, Baylor University College of Medicine, Houston, Texas.

Before consideration of the several specific aspects of serious poliomyelitis, certain statements of general principles are in order. A patient with poliomyelitis who exhibits any suggestions that serious involvement may ensue **must not** be left alone. He must be assured of an absolutely free airway at all times. One must be alert to the possible appearance of the various complications, particularly pulmonary, such as airway obstruction, atelectasis and pneumonia. Frequent observations of pulse, blood pressure, and body temperature should be made. The vital capacity should be estimated at regular intervals. This latter can be accomplished using the B. M. R. machine by having the patient put forth a maximal effort toward inspiration and expiration. A falling vital capacity is of very serious import, and necessitates constant observation of the patient for indications of hypoxia and CO_2 retention resulting from progressive underventilation. This will be indicated by restlessness, apprehension, either sleeplessness or lethargy, sensorium changes, and then either following or accompanying these signs one detects a florid appearance, rising pulse, rising blood pressure, sweating, pupillary constriction, and then cyanosis, panic, muscle twitching, coma and death if the sequence is not interrupted by appropriate measures to assure adequate ventilation.

Respiratory Muscle Paralysis

If, as a result of the invasion of the virus of poliomyelitis into the large motor cells innervating the muscles of respiration, a patient has respiratory muscles whose action is so impaired that he must either put forth conscious effort to utilize that remaining, or suffer the consequences of insufficient breathing, becomes a candidate for artificial respiration. In any case the patient with decreasing respiratory muscle function is ultimately a candidate for mechanical aid to respiration in at least 75-80% of cases. It should be pointed out that the patient may not be consciously aware of his respiratory muscle paralysis, and this appears to be true especially in children. Recognition of this early state of affairs is not less important than the recognition of the obvious terminal state of asphyxia with its agonal struggle for breath. If the vital capacity falls toward 30% of predicted normal, the patient is to be considered strongly for artificial respiration. Even more important than any one evaluation, unless the patient is comprised when first seen, is the serial evaluation of the status of the activity and reserve of the respiratory muscles. The fluoroscope is a valuable tool for guiding action in a particular case.

In deciding whether to employ mechanical aids or not, one should err on the side of putting them to use too soon because, as mentioned above, 75-80% of individuals with respiratory muscle paralysis ultimately require artificial respiration in the course of their acute disease. In our experience nothing is lost, and no harm is done, by putting an individual in a tank respirator who subsequently proves not to have required it for prolonged periods. On the other hand, much is to be gained by the avoidance of the emergency institution of artificial respiration.

One very important factor in the utilization of the tank respirator is the proper psychological preparation of the patient for this move. The equipment must be checked for proper function prior to its use, and it should be kept near to but out of sight of the patient for whom its use is being considered. Then the patient must be reassured that he will be helped by this move, and that he will **not** be left alone at any time, and, of great importance, that the use of the respirator is, in all likelihood, temporary. In point of fact, it is our experience that over 80% of individuals requiring breathing aid for periods greater than two (2) weeks do regain completely spontaneous and unassisted breathing.

If a patient requires artificial respiration for any reason, the tank respirator is the only machine presently recommended as a primary breathing device. The other forms of breathing aid are reserved for use in a stepwise and incremental fashion as decreasingly efficient devices in the process of aiding the patient toward spontaneous and unassisted breathing during his recovery period. A table of suggested settings is given below. Adjustments will frequently be required to take care of an individual patient's needs, and repeated checks of tidal exchange are indicated to keep that exchange optimum for the circumstances of each patient situation.

Age	Rate	Pressure
0 — 2	30 — 36	— 12 + 0
2 — 5	24 — 30	— 15 + 0
5 — 10	24 — 26	— 15 + 0
10 — 15	20	— 15 + 0
Adult	18	— 16 to — 18 + 0

Without doubt suitable regulation of respirator rate is the most important adjustment which will effect proper patient-respirator syncronization.

Swallowing Difficulty

Involvement of the structures activated by the nucleus ambiguous present rather knotty prob-

lems in management. Individuals who cannot swallow effectively usually present signs and symptoms of (1) excessive spitting, throat clearing, and drooling, in the older patients; (2) audible gurgles in the airway when checked with the stethoscope bell; (3) pooled frothy white secretions seen in the oropharynx on inspection; (4) restlessness and sleeplessness resulting from the patients unwillingness to sleep for fear of aspiration. Children are sometimes exceptions to this and must be watched very carefully for indications of aspiration which may occur with alarming suddenness; (5) nasal voice, in patients of all ages, offering a suspicion of palatal paralysis and confirmed when inspection is made while the patient says "AH," is an important sign of brain stem disease but in itself does not necessarily indicate swallowing difficulty which is due to pharyngeal constrictor paralysis or incoordination. It is not wise, therefore, to check for water regurgitation through the nose, particularly in the younger patient, because of the danger of aspiration due to accompanying pharyngeal paralysis.

In the management of this problem one should cautiously and judiciously try the conservative approach before undertaking tracheotomy, unless there is evidence of aspiration with compromise of respiratory exchange when the patient is first seen, or aspiration is eminent. This latter situation is a strong probability in the lethargic child.

The conservative approach to the problem of swallowing difficulty includes the use of positioning, and intermittent or constant suction. The position of choice is either side lying or prone with the feet 10-15 degrees higher than the head. Children must be watched with especial care during turning because of the ever-present danger of aspiration. Older children and adults who do not exhibit excessive amounts of mucous, and are able to cooperate, can ofttimes be taught to suction themselves. If intermittent suction cannot handle the amount of mucous present, then continuous suction through a disposable plastic nasal oxygen catheter may be tried. If this is not successful, then tracheotomy is to be undertaken. No hard and fast all encompassing rules can be laid down for whether or not, or when, to do a tracheotomy, but in our experience the following circumstances serve as useful guideposts, when coupled with clinical judgment and evaluation of each individual case:

Tracheotomy is indicated if:

1. There is failure of the conservative management of swallowing difficulty so that a free airway is not being maintained.
2. There is a combination of airway obstruction and respiratory muscle paralysis of sufficient degree to require artificial respiration, then tracheotomy is a must.
3. There is the presence of a pulmonary complication (atelectasis, pneumonia, etc.) trial of an airway, such as the bronchoscope, is quite often useful in this type of situation to help determine the value to be derived from tracheotomy.
4. The patient exhibits lack of cooperation with the cycling of the tank respirator and has been compromised by underventilation and acidosis—glottic incoordination.
5. There is disturbance of central respiratory regulation and the patient is in circulatory collapse and coma, then he must be assured adequate ventilation.
6. There is vocal cord paralysis with resultant laryngeal stridor, then this obstruction is to be by passed.

Disturbances of Central Control

Disturbances of central control usually involve the regulation and integration of either the respiratory system or the cardiac vasomotor system. This type of involvement is fortunately rather rare for it is here that the greatest fatality rate appears.

Involvement of the respiratory center(s) exhibits as a rapid, shallow, irregular, incoordinate and frequently ineffectual type of breathing pattern. Irregular breathing patterns of gasps followed by periods of apnea are seen. Here the fluoroscope is also quite useful for it will demonstrate the incoordinate activity of the muscles of respiration. Treatment in this situation is directed toward offering warm highly humidified oxygen. Artificial breathing aid is indicated. Even though it has, in the past, been recommended that the tank respirator is contraindicated in the face of incoordinate breathing, we take the opposite stand for it can be shown that even though the patient does not cycle with the respirator at each stroke of the bellows, he does so cycle with sufficient frequency to make artificial respiration feasible and beneficial.

Treatment is directed to each event as it may occur, and any or all of the above may occur in any combination. **Hypertension** may be handled by intramuscular Magnesium Sulfate or by the newer preparations of Rauwolfia Serpentina for

parenteral use. **Hyperthermia** may be treated by cooling sponges and intravenous alcohol is often of value if skin circulation is found to be poor. **Peripheral circulatory collapse** is approached by titrating the blood pressure upward with ephedrine or nor-epinephrine. Myocardial failure is treated with digitalis, mercurial diuretics and sodium restriction. Cardiac insufficiency may be incident to pulmonary complications or gravely aggravated by them.

Summary

The broad problems of management of the acute seriously involved poliomyelitis patient are outlined. The importance of early recognition of respiratory muscle paralysis, swallowing difficulty, disturbances of central control of respiration and cardiac action, airway obstruction, and the general complications are discussed briefly and principles of the management of each are presented.

SECOND WORLD CONGRESS OF CARDIOLOGY DRAWS 3,100 FROM 50 COUNTRIES

A total of over 3,100 registrants from fifty nations attended the Second World Congress of Cardiology which was combined with the Twenty-Seventh Scientific Sessions of the American Heart Association at the National Guard Armory in Washington, D. C., September 12-17. About one-third were physicians from abroad.

Dr. Paul D. White, **Boston,** who served as President of the Congress, was elected President of the International Society of Cardiology which sponsors these Congresses. He succeeded Dr. Charles Laubry of Paris, who has held the post for the past several years, and who presided over the first international cardiology congress in Paris in 1950. Other officers named at a meeting of the Society's Council include: First Vice President, Prof. Ignacio Chavez, Mexico City; Second Vice President, Prof. D. E. Bedford, London; Secretary-General, Prof. Pierre Duchosal, Geneva; Treasurer, Dr. Louis N. Katz, **Chicago;** Assistant Secretary, Dr. John Palmer, **Montreal.**

Brussels, Belgium, was chosen as the scene for the Third World Congress of Cardiology to be held in 1958. The Inter-European Congress of Cardiology will be held in Stockholm in 1956, and the Inter-American Congress of Cardiology will convene in Havana in the same year.

The next regular Scientific Sessions of the American Heart Association will be held in conjunction with the Association's Annual Meeting October 22 through 27, 1955, at the Jung Hotel in **New Orleans.**

Copies of the printed program for the Second World Congress of Cardiology are still available at $3.00 a copy from the American Heart Association, 44 East 23rd Street, New York 10, N. Y. The 559-page volume contains abstracts of papers presented at the formal scientific sessions. The abstracts are printed in English, with translations in Interlingua, a new international language, and in some cases in their original language.

"ATLAS OF CONGENITAL CARDIAC DISEASE"

Classic Monograph by
MAUDE ABBOTT
Reprinted by American Heart Association

In response to numerous requests from physicians, students, scientific workers and libraries throughout the world, the American Heart Association has reprinted the "Atlas of Congenital Cardiac Disease," by Maude F. Abbott. This classic monography, a critical analysis of 1,000 cases of congenital cardiac anomalies, was first published by the Association in 1936. Long since out of print, it has now been reprinted in a limited edition of 1,500 numbered copies exactly as it appeared originally.

The work of Maude Abbott, who died in 1940, served to bridge the gap between the previous unsystematic and largely descriptive knowledge of congenital cardiac defects and the present era of precise diagnosis and dramatic surgery. Her systematic study and classification opened the way for the practical developments of the past two decades.

The monograph was published largely at the suggestion of and with the encouragement of William W. Francis of the Osler Library, McGill University, **Montreal,** and with the permission of the executors of Dr. Abbott's estate.

The volume, which was printed by Peter F. Mallon, Inc., Long Island City, is available at a cost of $5.00. Copies may be obtained from the National Office of the American Heart Association or through affiliated heart associations and medical booksellers.

THE USE OF CORTISONE DURING PREGNANCY

EDWIN J. DeCOSTA, M.D.*

It is now six years since cortisone and corticotropin were first introduced to the medical profession as hormones possessing most unusual therapeutic properties. The expression "unusual therapeutic properties" is employed because these hormones have found their greatest use in the treatment of conditions which are not associated with known endocrine dysfunction. Their action therefore is pharmocological rather than physiological.

We were taught to use endocrines primarily for their physiological effect. For example, we use thyroid extract in the patient with myxedema to correct a deficiency, a failure of the thyroid gland to elaborate sufficient hormone. We use estrogens during the climacteric to suppress pituitary activity which normally is held in balance by the ovarian secretions. But with the adrenal hormones this basis rationale does not apply since in most instances adrenal function is normal. Of course, there are occasions requiring the use of adrenal hormones for replacement or suppressive therapy, but these are rare.

How Does Cortisone Act? Although a great deal of research has been undertaken, we still do not know much about the mechanism of the therapeutic action. In some way tissue reactions to noxious substances are altered, whether these reactions are due to bacteria, toxins, or allergens. Actually, cortisone does not cure—it alters the host reaction during which time the disease usually runs its course. If the condition is not self-limited, it becomes necessary to administer the hormone continually if one expects sustained improvement. Further, the adrenal hormones play an important role in metabolic processes, including those associated with mineral and water balance.

Although it is not our purpose to consider corticotropin, this discussion would be incomplete without at least a word to set the pituitary hormone (ACTH) in proper perspective. Gonadal activity is largely controlled by the gonadotropic hormones of the pituitary. In a similar way, adrenal cortical activity is controlled by tropic hormones of the pituitary. The adrenal cortex is divided histologically into three zones. It would be a safe guess to hypothecate at least three cortical hormones. Actually some twenty-seven different steriods have been isolated from the adrenal cortex but most of these are probably intermediate metabolic products or the result of the extraction process. We do not know which steroids constitute the true hormones but we do know that one is a cortisone-like substance, probably hydrocortisone (compound F). Several other hormones, mineral regulating and sex-like, are recognized and may or may not be under the same tropic control. At any rate, since we are concerned with cortisone, we will largely ignore the other cortical hormones. And since the cortisone-like hormones have similar effects we can say that whether we give cortisone or stimulate the adrenals with corticotropin to turn out their own corticoids makes little difference, as long as the adrenals are normal. Obviously giving ACTH to a patient after bilateral adrenalectomy or with diseased adrenals would be ineffectual since there is no healthy gland to respond. So much for corticotropin; henceforth cortisone, hydrocortisone, and corticotropin will be considered synonymously as "cortisone."

Why Would One Want to Use Cortisone During Pregnancy? Before answering the question specifically, let us generalize and say: for the same reasons that one would use cortisone in the non-pregnant patient, providing administration does not produce effects detrimental to the pregnancy. Before using cortisone, therefore, we should know what might happen to the conceptus.

It is interesting to note that much of the early investigation of cortisone was directly on the human animal. There was good reason for this: cortisone was scarce and was being utilized to investigate conditions which were not easily reproduced in the experimental animal. Occasionally conception occurred during these investigations. In retrospect, this was fortunate because we learned that in the usual therapeutic dose, cortisone does not disturb pregnancy in the human. On the other hand, later animal studies revealed that cortisone could disturb gestation, leading to abortion, congenital anomalies, still-birth, and premature labor. These observations serve to remind us again that one cannot and one should not translate the results of animal experience into human behavior. What is good for the goose may not be good for the gander.

Read before the Seventy-eighth Annual Session, Arkansas Medical Society, Fort Smith, April 20, 1954.

*Assistant Professor, Department of Obstetrics and Gynecology, Northwestern University Medical School, and Attending Obstetrician and Gynecologist, Passavant Hospital, Chicago, Illinois.

You may ask **Why Should Cortisone Have Any Effect on Gestation?** The functions of the glands of internal secretion are closely interrelated. This is particularly true of those glands associated with pituitary activity—the gonads, thyroid and adrenals. Pregnancy is a period of greatly increased glandular activity. As part of this, the adrenals become hypertrophied. We know that chemically some of the adrenal steroids are strikingly similar to the ovarian hormones. Simple logic suggests therefore that the adrenal hormones may play an important role in gestation.

It was inevitable that cortisone would be given to pregnant women. It would happen accidentally—conception occurring during the time that cortisone was administered. It would happen purposely, being prescribed during pregnancy for indications which may be grouped as follows:

1. In the treatment of conditions which existed prior to pregnancy and unrelated thereto;

2. In the treatment of conditions arising during pregnancy and still unrelated thereto; and

3. Experimentally in order to observe the effects of cortisone in normal and abnormal gestation.

What Are These Conditions, Unrelated to Pregnancy, in Which Cortisone is Indicated? They include the various diseases for which cortisone is commonly believed to be beneficial in the non-pregnant patient.

Rheumatoid arthritis usually improves remarkably during pregnancy. It was the knowledge of this phenomenon which led to the original investigation of the steroids as antirheumatic agents. Thus during pregnancy there is little indication for cortisone therapy in rheumatoid arthritis.

Acute rheumatic fever may occur during pregnancy. When it does we have a real indication for using cortisone which, while not curing the disease, at least makes the patient comfortable during a critical period.

Acute disseminated lupus erythematosis is a most serious disease. Cortisone is capable of inducing remission and some patients have been carried for years in good health on small maintenance doses. There are now several references in the literature to women who have been under treatment during the course of their pregnancy and have given birth to healthy, living children. The condition is rare but steroid therapy is the best available.

There are other rare conditions that should be kept in mind. We recently had occasion to review the history of a 23-year-old primigravida who suddenly developed petechial and ecchymotic hemorrhages in the third month of gestation. A diagnosis of thrombocytopenic purpura was promptly made but therapy was directed solely toward blood replacement. The patient died in three days. Had the consultant but remembered any one of several recent references to the astounding response of idiopathic thrombocytopenic purpura to the steroids—in this instance particularly to ACTH—the patient might have survived. In the treatment of this hemostatic defect 200-400 mg. cortisone or 100-160 mg. ACTH are administered daily. Eventually splenectomy may be necessary but one stands an excellent chance of inducing remission by prompt hormonal therapy.

In passing, you should remember that acquired hemolytic anemia of unknown etiology may also respond dramatically to cortisone therapy.

Troublesome allergies exist during pregnancy. These may range from a variety of skin reactions to asthma. Here, too, the steroids often provide excellent relief. And the same may be said for their effect on various inflammatory eye conditions. In the latter, topical application will generally suffice.

Is Cortisone Ever Indicated During Pregnancy for Replacement Therapy? Yes. Although the occurrence of pregnancy and Addison's disease is rare, the literature reveals some forty case reports. Cortisone in small doses is used with desoxycorticosterone and a high sodium intake. During labor and delivery, trauma and analgesics and general anesthetic drugs should be avoided. Careful management has resulted in a favorable prognosis for an otherwise very serious complication.

Let us now turn our attention to the third category of indications, namely, the experimental use of steroids in the study of their effects on normal parturients and those patients who present unusual conditions which theoretically might be benefitted by the use of cortisone. But first, **Is There Any Danger in Giving Cortisone to the Pre gnant Woman?** There is no indication of any ill effect either to mother or child, when therapeutic doses of cortisone are used. This is important when we recall that in animals a variety of unfavorable reactions have been reported. However, interruption of pregnancy in the rabbit and congenital anomalies in the chick and the mouse have resulted from larger doses than those given to humans. There is not a single instance re-

ported in which the human fetus has been damaged.

Experimentally, cortisone has been used in an effort to combat hyperemesis, toxemia and erythroblastosis.

Is Cortisone of Any Value in the Treatment of Hyperemesis? The rationale for the use of cortisone presupposes a functional deficiency of adrenal cortical hormones. This is based on the observation that the symptoms of anorexia, malaise, lethargy, fatigue, of nausea and vomiting and epigastric pain are similar to those of Addison's disease. This theory was first proposed by Kemp in 1932. During the thirties there were several enthusiastic reports indicating the efficacy of crude adrenal cortical extracts. However, in spite of the favorable accounts, even the investigators lost interest and for over a decade adrenal extracts were forgotten. One can only assume that further experience proved the therapy valueless. It might be emphasized that these extracts were not pure but were mixtures of many substances, all in infinitesimal amounts. It might also be mentioned that there has never been any real evidence of adrenal insufficiency during early pregnancy.

Be that as it may, with the advent of pure potent steroids several investigators have treated patients complaining of hyperemesis with cortisone as well as other adrenal hormones. A preliminary report on the use of cortisone in hyperemesis is to be found in the lay press in 1951. However, the first publication in a medical journal did not appear until 1953, and that report does not stand critical evaluation. Although 29 patients were treated, in only 7 was the condition severe enough to be called hyperemesis. Of the 29, 23 patients were completely cured within 36 hours. The dose varied from 25 to 75 mg. per day and was continued, on the average, for 21 days. There were no controls which makes it exceedingly difficult to evaluate the reported effects. Similar success has been claimed for desoxycorticosterone—the mineral-regulating adrenal hormone. As you know, practically anything you can name has been used at one time or another in the treatment of hyperemesis and always with enthusiastic endorsement—if only for a passing moment. Even though the value of cortisone is questioned, there is a bit of significant information to be gleaned, namely, that when given early in pregnancy there was no evidence of maternal damage or of fetal damage. I make this statement mindful of a letter written to the editor of the American Journal of Obstetrics and Gynecology in which the author reported three cases of congenital anomalies occurring in women who had been given cortisone for vomiting. I do not know why the letter was ever written since the author points out that cortisone was not started in these patients until after the time of major ontogenic development.

Of What Value is Cortisone in the Treatment of Toxemia of Pregnancy? The first report on the use of cortisone in the treatment of toxemia came from Moore and his associates in Dublin. Their initial series consisted of six patients who were considered to have severe pre-eclampsia. Cortisone did not significantly alter the blood pressure nor modify the proteinuria in any of these patients. However, there was some decrease in edema and subjectively the patients improved: their headaches lessened and visual disturbances subsided. We now know that subjective improvement is meaningless since cortisone induces euphoria. There was nothing in Moore's work to indicate that cortisone had any merit. In fact, one of his patients actually convulsed while in labor.

In spite of these negative results, the enthusiasm and implications of value have led to continued investigation by others. These reports are even less encouraging than Moore's, but they always seem tinged with the hope: "Maybe we have something, if we but dig a little deeper." You may be assured that there is nothing in the literature nor in my personal experience which indicates that cortisone, or ACTH, has any value whatsoever in the treatment of toxemia of pregnancy.

There is, however, one observation worthy of note. These patients were not made worse by cortisone. You will recall that the adrenal steroids tend to cause the retention of sodium and water. In large doses they even lead to hypertension and proteinuria. One might expect an unfavorable effect on the toxemia, but this did not occur. In passing, however, I want to mention that I have observed the incidental development of pre-eclampsia in a sensitized RH(—) patient while on cortisone therapy, and that the literature contains one case report of severe pre-eclamptic toxemia developing in a pregnant patient with Addison's disease. It is probable that cortisone does not enter into the problem of toxemia at all.

We now ask the question, **Of What Value is Cortisone in the Treatment of Erythroblastosis Fetalis?** This is particularly timely in view of a recent article in the A. M. A. Further, since it

deals with a problem which is of great lay interest, we must guard against misinformation.

Cortisone is able to alter antigen-antibody reactions. Just how this comes about is not known, but apparently it does not affect actual antibody production. Since erythroblastosis is caused by an antigen-antibody reaction, there is logic in the assumption that adrenal cortical hormones might modify this reaction. The literature reveals over seventy instances in which cortisone and/or ACTH have been employed in an effort to salvage the fetus of the sensitized mother. The reports are favorable and unfavorable. But again the enthusiasts take the limelight. The report of Hunter in the March 13 issue of the J. A. M. A. had reached the laity in the November 2 issue of Time Magazine. This article deals with the treatment of 56 sensitized Rh(—) women, 21 of whom had previously given birth to stillborn children. Of these 21 women, 15 were delivered of babies that survived, although 3 of the infants were Rh(—). Still 12 survivals out of 21 unfavorable pregnancies is an amazing experience, and, I might add, at total variance to my own. It is also at variance with present concepts of erythroblastosis. Hunter stated that before the use of cortisone he had never seen an Rh(+) child born alive to an Rh(—) mother who had previously delivered a stillborn fetus. While the prognosis is admittedly poor, a recent study undertaken jointly by Northwestern University Medical School and the Lying-In Hospital of the University of Chicago Medical School reveals that there is a 23.7% survival rate of Rh(+) babies. This knowledge is often overlooked in evaluating the survival of infants born to sensitized Rh(—) mothers. It alone may account for the favorable preliminary reports based on the use of hapten, anhydrohydroxyprogesterone, ethylene disulfate and methionine. Further critical study showed all these substances to be of questionable value.

The same may apply to cortisone. It is difficult to reconcile the statement by Hunter that he has never seen an Rh(+) child live after the mother has given birth to an erythroblastotic stillborn infant with our observed 23.7% survival incidence. Either he has not seen enough unfavorable pregnancies or the severity of erythroblastosis differs in different locales. We believe that once sensitization of the mother has occurred, all subsequent Rh(+) children will be erythroblastotic, but, for some unknown reason, not necessarily of the same degree. A live-born erythroblastotic baby, excepting those with fetal hydrops, stands a 90% chance of survival if adequately treated.

What Do We Mean by Adequate Treatment? Erythroblastotic babies must be closely observed since many are without clinical evidence of the disease at birth. Replacement transfusion is performed at once if the baby shows clinical evidence of erythroblastosis—hepatosplenomegaly, edema, jaundice, r.b.c. less than 4.5 million, or hemoglobin less than 13.5 gm. Further, it is usually utilized even without clinical evidence of erythroblastosis if the baby is premature (less than 38 weeks gestation), if male, or if there is an unfavorable history in a previous sibling such as stillbirth, fetal hydrops, or kernicterus. The mother's titer during pregnancy is suggestive of the degree of involvement and where 1:16 or higher, transfusion is often necessary. A (+) direct Combs indicates that Rh antibodies are present on the fetal r.b.c. and that transfusion must be employed at the first evidence of hemolysis. You will remember that by prompt transfusion 90% of living erythroblastotic babies, other than those manifesting fetal hydrops, can be saved. In Hunter's series all the babies were transfused. Thus we can understand the high survival rate—you and I would get similar results. But the part that is difficult to explain is his marked decrease in fetal hydrops and intrauterine death. In his series the stillbirth rate of erythroblastotic babies dropped from 17 to 3%. In our experience there was no drop. Thus the poor results, we acknowledge, are due to babies which could not be saved—they were already dead or damaged beyond repair. Cortisone definitely did not improve the chances of live birth.

I had not intended to take Hunter apart, but since we are considering the use of cortisone during pregnancy and since its use in the treatment of erythroblastosis is currently ballyhooed. I have no choice but to discuss the publicized results of the protagonist.

A word about maternal titers before leaving the subject. They are important only as sign posts of prognosis. Generally a titer of 1:16 or higher indicates trouble and 1:64 or above, serious trouble. However, we have observed rising titers associated with an Rh(—) baby and falling titers with most severe involvement. No one claims that cortisone favorably affects the titer; it has no influence on titer at all.

We can thus summarize the effects of cortisone in this third category—that in which it has been used experimentally in normal and abnormal pregnancy—by stating that as of the present, there is no evidence that cortisone is of any benefit in any of the conditions for which it was used.

minimal

side

effects

ACHF

LEDERLE LABORATORIES DIVISION AMERICAN Cyanamid co

One of the notable qualities of ACHROMYCIN, the Lederle brand of Tetracycline, is its advantage of minimal side effects. Furthermore, this true broad-spectrum antibiotic is well-tolerated by all age groups.

In each of its various dosage forms, ACHROMYCIN provides more rapid diffusion for prompt control of infection. In solution, it is more soluble and more stable than certain other antibiotics.

ACHROMYCIN has proved effective against a wide variety of infections caused by gram-positive and gram-negative bacteria, rickettsia, and certain virus-like and protozoan organisms.

ACHROMYCIN ranks with the truly great thera peutic agents.

OMYCIN*

HYDROCHLORIDE
Tetracycline HCl Lederle

l River, New York

Lederle

*REG. U.S. PAT. OFF

Are There Maternal Contraindications to the Use of Cortisone? Even though there are no reports of maternal damage, cortisone is not an innocuous drug. There are certain side effects which must be considered whenever cortisone is used. These become manifest with prolonged administration if the dose exceeds 75 mg. per day. They include psychic disturbances, fluid retention with edema, hypertension, occasionally glycosuria, acne, weakness, and alterations in healing. Because of these reactions, there are definite contraindications to the use of cortisone, whether the patient is pregnant or not. The commonly accepted contraindications are mental diseases, congestive heart failure, chronic nephritis, hypertension, Cushing's syndrome, diabetes mellitus, peptic ulcer and tuberculosis.

Except in the case of toxemia, one has not considered giving cortisone to any pregnant patient presenting contraindications. However, it will be remembered that neither the hypertension nor edema of toxemia has been increased by cortisone. These observations may be explained by an increased tolerance of the pregnant patient to corticoids. As a result of the normal endogenous increase, the body may be less sensitive to exogenous corticoids.

I do want to call your attention to several theoretical and practical problems associated with the administration and withdrawal of cortisone. One is the increased excretion of potassium which is brought about by cortisone. If this loss is not made up by increased potassium intake, the patient may develop hypopotassemia. Cortisone also seems to suppress thyrotropic hormone production, with the eventual development of symptoms of mild hypothyroidism. Delayed wound healing and decreased resistance to infection have been observed in non-pregnant patients receiving cortisone, but I know of no instance where these complications occurred in pregnant patients.

More important perhaps is the effect on adrenal function. Cortisone inhibits corticotropin formation with consequent depression of adrenal function. Following therapy, the adrenals require a period of time before they are again capable of normal function. The larger the dose and the longer the administration, the more profound the depression. If during the period of restitution the patient incurs unusual stress, she may react unfavorably. Fortunately we do not know of such occurrences during pregnancy but it has been observed in non-pregnant patients and occasionally with fatal outcome. To play it safe, therefore, we advocate the gradual reduction of cortisone over a period of several weeks, presumably long enough to re-establish partial adrenal function. But complete recovery may actually require several months. If the patient is subjected to any severe stress-surgery, accident or serious disease—during this time, it seems wise to consider the resumption of cortisone therapy, at least during the period of stress.

In conclusion, I would like to emphasize that even though cortisone may interfere with pregnancy in animals, there is no evidence of this effect in the human. We have also seen that although the indications for the use of cortisone during pregnancy are few and far between, steroid therapy can be of great importance in the management of a variety of medical conditions unrelated to pregnancy. However, for those conditions specifically allied to pregnancy, hyperemesis, toxemia and erythroblastosis, there is no indication that cortisone has any merit.

STUDY SHOWS ANTICOAGULANT DRUGS EFFECTIVE IN REDUCING DEATH RATE FROM HEART ATTACKS

Anticoagulant drugs are proving effective in reducing the death rate and complications among patients who have suffered a recent heart attack, according to the findings of the Committee on Anticoagulants appointed by the American Heart Association to conduct an extensive study of these drugs. The 680-page report of the Committee entitled, "Myocardial Infarction: A Study in 1,031 Cases; Its Clinical Manifestations and Treatment with Anticoagulants," has been published by Grune & Stratton, New York ($8.50). The authors are Irving S. Wright, Charles D. Marple, and Dorothy Fahs Beck.

The result of seven years of investigation, the report is based on work done in 16 widely scattered cooperating hospitals. The Committee on Anticoagulants was established by the American Heart Association in 1946, following initial reports of experience with anticoagulants which indicated that they might influence favorably the outcome of heart attacks.

The volume provides a full analysis of the entire series of cases, and includes 480 tables and charts. Dr. Wright, Professor of Clinical Medicine at Cornell University College of Medicine, **New York,** was Chairman of the Committee. Dr. Marple, presently Medical Director of the American Heart Association, acted as Coordinator of the study. Dr. Beck directed the statistical analysis.

★ Editorial ★

"With this ink I have just poured may none but honest words be penned." — Christopher Morley in "A Grace Before Writing."

INTEGRATION OF THE PATIENT

ALFRED KAHN, JR., M.D.

In a sense the position of the patient in our modern medical schema is analogous to the final common pathway concept developed by Sherrington and other notable neurophysiologists. Neurologically, the motor nerve running from the spinal cord to the muscle has been called the final common pathway. The final common pathway is acted upon by impulses coming from many diverse sources; mechanistically it could be pictured as an arborizing process on the proximal end of the motor nerve, and to which nerves from the cerebrum, mid brain, cerebellum, etc., may contact. These different influences are so to speak vectored by the one motor nerve—that is the action of this one nerve is a compromise of all the many forces that act on its proximal end.

The sick patient is the final common pathway of medicine. This has advantages and disadvantages. With the development of specialization in medicine the patient may be actively diagnosed and treated by a number of physicians at one time. Often they represent diverse schools of thought and action. When these doctors with differing outlooks and interests focus on one problem in one patient, the result of their varying view points should give a clearer picture of the disease than could be obtained by one person viewing one facet of the problem. In a medical situation where several opinions are being expressed, it is of the greatest importance that some one individual take the unrelated facts and knit them into an orderly integrated picture. Some facts justify more weight than others; red herrings should be recognized, and the areas of disagreement resolved. Failure of the principal physician to integrate information about the patient may be disastrous. For example, the isolated report from the cardiologist that the EKG tracing is abnormal does not mean that the patient has heart disease. In a large group of perfectly healthy Air Corps Cadets, Dr. Paul White found some abnormal EKG tracings although there was no evident heart disease. An isolated X-ray finding of a deformity in the cecum does not necessarily mean cancer. With no other knowledge of the case, failure of barium to fill the cecum is strongly suggestive of neoplasm. On the other hand, with all the clinical data about the patient amassed and correlated it may become evident that the deformed cecum represents a recent surgical operation, tuberculous cecitis, etc.—that is although the X-ray finding is not the usual type of cecum, it does not represent a surgical disease and possibly is not even germane to the patient's chief clinical problem.

The desirability of organizing the patient's clinical data has been presented in terms of more than one physician and stresses the need for a principal physician to integrate the facts. However, it is equally applicable in terms of the single practitioner, who must care for many types of disease in his patients. Knowing his patient well, the general practitioner is less likely to attach undue importance to isolated, misleading facts than the physician who makes a limited examination, yet the possibility for clinical "red herrings" exists here, too.

The hallmark of the mature physician is the ability to sift relevant data concerning the patient from the welter of irrelevancies, and to take these pertinent facts and integrate them into an accurate clinical picture.

Arkansas physicians have not been contributing to the American Medical Education Fund in large numbers. These columns have on various occasions called attention to the funds given our own Medical School from this fund and to what is being done elsewhere.

Let's all quit talking and go to doing. Make your check to AMEF c/o American Medical Association, 535 North Dearborn Street, Chicago, Illinois.

The Journal suggests that a "Medical Education" week be set aside in October of each year, and that the various programs be planned for that week—including the Academy of General Practice, the various chapters of national organizations, and one or two post-graduate programs as planned by the University of Arkansas Medical School.

A consolidation of these programs would let a busy physician attend one or more such meetings—might augment attendance, and interest, and provide an autumn week to complement the meeting of the Arkansas Medical meeting in the spring. The mechanics of this cooperation could be accomplished through the office of Postgraduate Instruction in the Medical School, and we believe this would be a move in a good direction.

MEDICAL MEETINGS

The October meeting of the Arkansas Academy was an outstanding success. More than 125 physicians were in attendance, and a high grade program evolved.

The Academy opened a month which was filled with many and various meetings. Seven programs were held during the month, which, in our time, is an all time high.

The Newsletter would point out that something might be gained by joining hands in these programs, so there will be no conflicts, and no duplication. Since the faculty of the School of Medicine in Little Rock is the backbone of all such programs it would be appropriate if these meetings be correlated with their office of postgraduate instruction. Failing this cooperation, the Newsletter suggests that with the recent successful meeting under his belt, President Ellis calls on the various organizations for a liaison meeting, and settle the problem before it gets any worse.—Newsletter, Arkansas Academy General Practice.

The Journal pauses in this month of kept, and unkept, resolutions, to dwell on the addition of many new hospital beds for this and the coming years. St. Vincent's Hospital in Little Rock is now open and the new and modernistic style has been the subject to many words of praise, many inches of newspaper advertising and comment, all well deserved. The new Ouachita General Hospital in Camden has likewise shed its swaddling clothes in the past few weeks and presented itself a step forward in healing, a credit to any county in the United States.

The Baptist Hospital, Little Rock, has been expanded and its service to the community of Arkansas vastly extended.

At Conway, Magnolia, and other Arkansas cities, hospitals have been opened, expanded, or voted on, during the past year. We rejoice with the people of the area served by these institutions. We are proud to know that members of the Arkansas Medical Society have had a guiding hand in the assembly line of their production. We know that with new labor-savers, and new and perfected equipment, that a better service can be rendered. We are proud of the organizations that are making Arkansas a healthier and a happier state in which to live.

With all these improvements and changes, we hope that something remains the same: the cool, gentle hands of the nurse who comforts us, and the encouraging smile of our friend, the family physician. These, we hope, never change.

We are beginning the new year with the publication elsewhere in this issue of the program as developed so far for next May 30-June 1 in Hot Springs. It is an ambitious one and should command a considerable audience. Chairman Alfred Kahn and his co-workers are up to their elbows to make the 79th annual Session worthy of any physicians time and study.

RESOLUTION

THE JOHNSON COUNTY MEDICAL SOCIETY

Whereas, God in His infinite wisdom has taken from our midst our colleague and fellow-member of The Johnson County Medical Society, Doctor Earle Houston Hunt, and

Whereas, we, The Johnson County Medical Society, in session duly assembled, do hereby authorize, resolve, and offer the following resolution:

Resolved, That in the untimely death of our beloved brother physician, Doctor Earle Houston Hunt, not only we, but the State of Arkansas, has lost one of its most efficient physicians. He was a graduate of Tulane University in the year 1909. He had practiced medicine and surgery in Johnson County ever since then. He was a Past President of the Arkansas Medical Society, a Fellow of the American College of Surgeons, and a delegate from the Arkansas Medical Society to the American Medical Association. His honors and offices in organized medicine have been many. He was President of the Johnson County Medical Society at the time of his death, a position he has filled many times.

Therefore, be it further Resolved, That The Johnson County Medical Society express to his wife, Mrs. Earle H. Hunt, and the family our sympathy at the loss of "Doctor Earle" and our appreciation for the faithful service rendered by him while in our midst.

Be it further Resolved, That this resolution be entered upon the permanent records of this Society and that the Secretary transmit a copy thereof to the family; also, that a copy be sent to the "Journal of The Arkansas Medical Society" and to the local papers for publication.

William R. Scarborough, Pres.
James M. Kolb, Sec'y-Treas.

Geo. L. Hardgrave,
C. C. Long, 12-6-54.
James M. Kolb,
Resolutions Committee

TUBERCULOSIS ABSTRACTS

A Review for Physicians

ISSUED MONTHLY BY THE NATIONAL TUBERCULOSIS ASSOCIATION

AN EXPERIENCE WITH THE LARGE ROUTINE CHEST FILM IN A RURAL HOSPITAL

By J. W. BOYD, M.D.

The Ohio State Medical Journal, September, 1954

In this era in which the lay press and various medical groups are persistently advocating routine, periodical physical examinations which include a chest roentgenogram the physician has an excellent opportunity to discover early lesions. Every physician knows that the best chances to cure a disease come in its early symptomless phase, when it usually responds to treatment. This is particularly true in tuberculosis and lung malignancy.

By definition routine chest examinations are those which are conducted to screen persons with abnormal changes of the chest from persons with normal chests. The patients with advanced disease concern us less than those with minimal disease. The former group will seek medical advice because of the distressing symptoms, but the latter will walk the streets with a minimal lesion, unknowingly jeopardizing their own lives and the lives of others. For mass chest surveys the 35mm., 70mm., or the four by ten stereoscopic films are available, as well as the full size film or 14 by 17 inch. Survey chest X-rays in hospitals or in the general population are approved as a screening device if so conducted that well-qualified professional and technical personnel are utilized and sincere efforts are made to follow-up the positive individuals properly.

Finding a chest lesion is only the beginning of the screening process. It is often difficult to differentiate tuberculosis from lung malignancy both clinically and radiographically. Any patient who presents an abnormal shadow on the screening film should have a more complete X-ray examination, including fluoroscopy, lateral projections and, many times, oblique projections. Tuberculin tests and sputum and gastric examinations for tubercle bacilli are essential. Cytologic examinations and bronchoscopy with biopsy should be done if indicated.

It should be emphasized that the admission chest film for the most part is a screening process and not diagnostic. Since the microfilm has been in use, numerous abnormalities of the heart and great vessels have been discovered which may have otherwise been overlooked.

In November, 1952, the hospital board, administrator and medical staff of Detwiler Memorial Hospital, Wauseon, Ohio, decided to do routine admission chest films on all patients over 12 years of age, admitted for a period of 24 hours or more. Only one examination would be done on a patient in a six-month period regardless of the number of admissions of that patient. As the hospital has only 60 beds with approximately 3,000 admissions yearly, the installation of a microfilm unit was impractical. It was agreed to use the large film or 14 by 17 inch. The fee charged was to be large enough to cover the expense of the radiology department but reasonable so that patients would not be discouraged from having the examination.

An interested and educated staff is a necessity if this program is to be successful. It is equally important that all of the hospital personnel understand the purpose of and cooperate in the program. The examination was not to be mandatory, but each staff physician was to explain to his patient its value and availability. Obviously a perfect record was not expected, but it is estimated that at least 95 per cent of the patients over 12 years of age obtained the chest roentgenograms.

The chest film should be taken as soon as possible after admission, in order to protect the hospital personnel and to assure effective follow-up if a lesion is discovered. The procedure increases in value if the recommendations of the roentgenologist for further investigation are followed and a final diagnosis is established.

Statistical studies have shown that the incidence of tuberculosis is higher in patients in general hospitals than in the general population. It has also been shown that there is more tuberculo-

sis among pregnant women than in the general population. It is often difficult to obtain an admission film on an obstetrical case. Therefore, it is advised that maternity cases be referred to the hospital for a chest film during pregnancy, preferably during the last trimester.

In a 12-month period a total of 1,205 admission films were taken at Detwiler Hospital. The films classed as "routine" do not include patients with chest complaints or patients suspected of a chest disease. Of the 1,205 films taken, 133 or 11 per cent, presented some type of significant abnormality or finding.

Analysis of Large Admission Chest Films Showing Significant Findings

Significant Findings	Number	Per Cent Distribution
Total	133	100
Abnormalities of the heart and great vessels	61	46
Rib abnormalities (all were cervical ribs except metastatic destruction in one case)	11	8
Diaphragm abnormalities	5	4
Lung disease—includes pneumonia, tuberculosis, bronchiectasis, fibrosis due to infection or occupation	50	38
Neoplasms	6	5

It must be stressed that the figures in the table represent roentgen diagnoses only and that only a small number of these have been proven to date. The first group of figures is most striking. The abnormalities of the cardiovascular system consisted largely of enlarged hearts or a cardiac configuration suggesting rheumatic heart disease. All films were taken at a 72-inch distance so that these were readily recognized. The study, although of a small number of cases, shows a much larger incidence of abnormal heart silhouettes than has been reported in surveys in which the small microfilm was used.

Several reported studies of surveys of admissions to general hospitals have shown that a routine chest X-ray discloses a higher percentage of abnormalities than any other single routine hospital laboratory examination. There is also a definite increase in the number of lesions detected on the large film (14 by 17) as compared to the microfilm. However, the microfilm is still undoubtedly the most satisfactory and economical method in large screening processes. In hospital screening the advantages of the large film must be considered. It is felt that the size of the hospital makes no difference.

A community-wide chest X-ray program involves large numbers of people and organizations. The community-wide survey also represents a unique opportunity for a community to rethink its tuberculosis and cancer control program. It can be the starting point for an all-out effort to eliminate tuberculosis and to conquer lung malignancy. Its success depends upon the breadth of understanding and exchange of ideas which the survey itself engenders in those concerned with its management.

In the hospital program the cooperation of all hospital personnel cannot be overemphasized particularly that of the medical staff. The investment of a few minutes of the time of the physician in explaining to the patient about the value of routine chest film and the expenditure of a relatively small sum of money on the part of the patient, may pay great dividends in years of life.

Obituary

H. D. BOGART, Marianna, died November 13 at the Methodist Hospital in Memphis. He had been taken to the hospital about two weeks before after suffering a heart attack. He was 72 years old.

Dr. Bogart had practiced medicine in Arkansas for over 50 years. He received a plaque in May, 1954, from the Arkansas Medical Society in honor of his 50 years of service.

A son of the late H. D. Bogart of Little Rock, he graduated from the University of Arkansas in 1906 and practiced medicine in Wheatley until 1915 when he moved to Marianna. He married the former Miss Scottie Smith in 1906.

Dr. Bogart was a member of the Arkansas Medical Society, the American Medical Society, and the Lee County Medical Association. He served on the Board of Stewards of the Methodist Church for a number of years. He was a member of the New Orleans Polyclinic and the New York Polyclinic. Dr. Bogart served at Fort Riley, Kansas, during World War I.

Survivors include his wife, a sister, and a granddaughter.

Funeral services were conducted Sunday afternoon at the Methodist Church. Burial was in Cedar Heights cemetery.

W. G. HANCOCK, 67, of Rison, died suddenly at his home on November 12. He had

practiced medicine for 40 years, was born near Hamburg, a son of the late Jesse and Betty Richardson Hancock. He attended Clary Training School at Fordyce, and was a graduate of the University of Arkansas School of Medicine. Before coming to Rison 23 years ago, he had engaged in the practice of medicine at Cotton Plant.

He was a member of the Arkansas Medical Society and secretary of the Cleveland County Medical Society. He had for a number of years been examining physician for the Cotton Belt Railway. He was a member of the Rison Methodist Church, and was a Mason.

Besides being actively engaged in the practice of medicine until his death, Dr. Hancock had farming interests near Rison.

Surviving are his wife, a son, and a sister.

Funeral services were conducted from the Rison Methodist Church. Burial was in Rison's Greenwood cemetery.

WALTER C. OVERSTREET, 60, Jonesboro, died December 3 in St. Bernard's Hospital after suffering a stroke at his home earlier in the afternoon.

He was born in Sedalia, Mo., and was graduated from the University of Missouri and St. Louis University School of Medicine. Dr. Overstreet did post-graduate work at Barnes General Hospital in St. Louis in recent years.

After interning at St. Vincent's Infirmary in Little Rock, he came to Jonesboro in 1918, and opened offices with the late C. P. McCracken, and the late E. J. Horner.

He was an active member of the First Methodist Church, and a long-time member of the Board of Stewards of the Church.

He was a past president of the Jonesboro Lions Club.

Dr. Overstreet was president-elect of the Craighead-Poinsett Medical Society when he was forced to retire from active practice in 1952.

He was a member of the Masonic Lodge and a Shriner.

Survivors include his wife, two children, two grandchildren, two sisters, and three brothers.

Funeral services were held in the First Methodist Church with Dr. Ethan Dodgen officiating. Burial was in Oaklawn Cemetery.

J. W. RAMSEY, 77-year-old retired Jonesboro physician, died in Campbell's Clinic in Memphis December 4 as a result of injuries suffered in a fall at his home.

He was born in Aledo, Ill., and attended grammar and high school there.

After graduation from high school he attended Lake Forest College and graduated from Rush Medical College.

He came to Jonesboro in 1910 and began his local practice. During World War I he served in the Army, spending nearly a year in France. He was discharged as a captain and resumed his practice here. In 1936 he was forced to retire because of failing health.

He and Mrs. Ramsey celebrated their golden wedding anniversary last year.

He was a member of the Presbyterian Church.

Survivors include his wife, a son, two brothers, and two grandsons.

Funeral service were held in the First Presbyterian Church with Dr. A. F. Fogartie officiating. Burial was in Oaklawn Cemetery.

J. A. VanBeber, 43, Gassville, died of a heart attack in Amarillo, Texas, on November 14, 1954. He had been in ill health for some time and was returning home when the attack occurred.

He was born near Cotter June 6, 1911, graduate of the University of Arkansas Medical School and practiced medicine in Gladewater, Texas, several years before returning to Gassville four years ago, when he bought the Baxter County Community Hospital there and took over active management of the institution.

Dr. VanBeber was a veteran of World War II, a member of the Methodist Church, and the Cotter Masonic Lodge. He was president of the Baxter County Medical Society, a member of the Arkansas Medical Association, Southern Medical Association, Texas Medical Society and the American Medical Association.

Survivors include his wife, a daughter, his mother, and a sister.

STATE A.M.E.F. CHAIRMEN TO MEET

American Medical Education Foundation state chairmen will kick off the 1955 fund-raising campaign with a meeting Sunday, Jan. 23, at the Sheraton Hotel, Chicago. This fourth annual meeting will launch officially the medical profession's concerted efforts to raise voluntary funds for the nation's medical schools.

Arkansas TRAVELING

And Clipping Bits Here and There

Our Social Security program also illustrates the point. It obviously assumes that people are individually too improvident or too incapable to protect themselves against old age. The state, therefore, takes over this responsibility. It must be admitted by even its partisans that this program runs contrary to development of self-reliance. Each social group seems to want more and more government protection. Manufacturers want tariffs; farmers want price supports; labor unions want guaranteed wages; universities want federal aid.—R. B. Robins, "G.P.," October, 1954.

And the doctors, Bob, thank Heaven, want nothing more than to be left alone, and to be allowed to practice free and independently of government dictation.

Dr. Merrill D. Prugh, President, Ohio State Medical Association—

"To be a good doctor, each one of us must:

"1. Make our services available at all times to all who need them.

"2. Make our fees fair to both the patient and the doctor.

"3. Make our personal interest in the patient known to the patient.

"If we will do these few simple things, public relations will be no unsolved problem and socialized medicine no threat. We will have the respect of the public and best of all, our own self-respect."

Mr. Neil McElroy, President, Proctor and Gamble Company — "Medical schools demand highest priority. As teaching centers they are at the heart of the medical sciences, as they are an indispensable source of medical research and progress. The lives of our fellow men cannot be placed in the hands of incompetent doctors. And we must never permit medicine to become a goverment 'commodity.' "

Dr. W. W. Bauer, Director, A.M.A. Bureau of Health Education—

"Direct selection of specialists by patients is an error which can lead only to disappointment. If all patients were to be served by specialists, these doctors would waste their valuable time seeing patients outside their specialized scope, and the referral of patients back and forth would constitute a parade beggaring description."

MISSISSIPPI VALLEY MEDICAL SOCIETY 1955 ESSAY CONTEST

The 15th Annual Essay Contest of the Mississippi Valley Medical Society will be held in 1955. The Society will offer a cash prize of $100.00, a gold medal, and a certificate of award for the best unpublished essay on any subject of a general medical interest (including medical economics and education) and practical value to the general practitioner of medicine. Certificate of merit may also be granted to the physician whose essays are rated second and third best.

Further details may be secured from Harold Swanberg, M.D., Secretary, Mississippi Valley Medical Society, 209-224 W.C.U. Building, Quincy, Ill.

A.M.A. PREPARES "FARM ACCIDENTS" EXHIBIT

How to keep 'em healthy "down on the farm" is the theme of a new exhibit now available for showings at local fairs, expositions and public gatherings from A.M.A.'s Bureau of Exhibits. Emphasizing the comparative hazards of farming with other industries, this informative "Farm Accidents" exhibit points up common farm accidents and ways of preventing them.

Causes and prevention of accidents in and around the home also are highlighted. In addition, a special section is devoted to the role youth can play in farm accident prevention. Audience participation is invited in the form of a "question and answer" silo.

We believe in the right and obligation of every doctor in good standing to care for his patients in a hospital, and to have a place in the operating room as surgeon, assistant, or observer according to his abilities and desires. Many patients are becoming aware that they need a doctor who can watch the whole course of their illness and with whom they can discuss fees, referrals and consultations.

For example, the Joint Commission for Accreditation of Hospitals should be under the control of the American Medical Association, and hospital staffs should be controlled by the whole hospital staff who could set up fair rules of hospital practice.—James A. Cosgriff, M.D., President, Minnesota Academy of General Practice.

A.M.A. OFFERS STANDARD NOMENCLATURE INSTITUTE

A new short course offering expert instruction and helpful suggestions on the correct way of utilizing "Standard Nomenclature of Diseases and Operations" in the hospital, doctor's office or clinic will be offered Feb. 7-8-9 at A.M.A. Headquarters, Chicago. Registration is limited to 150.

SOLVING SCHOOL HEALTH PROBLEMS

There is a Joint Committee on Health Problems in Education of the American Medical Association and the National Education Association which is currently preparing a manuscript to be entitled **Healthful School Living.** Scheduled for publication in 1957, this book will complete the series of three volumes covering various aspects of the school health field. Previous volumes were **Health Education** published in 1948 and **School Health Services** in 1953.

The 15th Annual Congress on Industrial Health, sponsored by A.M.A.'s Council on Industrial health, will be held January 25 and 26 at the Shoreham Hotel, Washington, D. C.

Following the general theme—"Goals of Preventive Medicine"—panel discussions will be presented on: (1) Industrial health as a major component in community health; (2) Training and recruitment of qualified professional personnel; (3) Medical care plans; (4) Workmen's compensation and rehabilitation, and (5) Health in the atomic age, stressing the need for modern protective methods of safeguarding the worker's health.

The Institute of Industrial Health of the University of Cincinnati will accept applications for a limited number of Fellowships offered to qualified candidates who wish to pursue a graduate course of instruction in Industrial Medicine. Any registered physician, who is a graduate of a Class A medical school and who has completed satisfactorily at least two years of training in an accredited hospital may apply for a Fellowship in the Institute of Industrial Health. (Experience in private practice or service in the Armed Forces may be substituted for one year of training.)

During the first two years, the stipends vary from $3,000 to $3,600 in the first year and $3,400 to $4,000 in the second year. In the third year the candidate will be compensated for his service by the industry in which he is completing his training.

A one-year course, without stipend, is also offered to qualified applicants.

Requests for additional information should be addressed to the Institute of Industrial Health, College of Medicine, Eden and Bethesda, Cincinnati 19, Ohio.

The Council on Postgraduate Medical Education of the American College of Chest Physicians will sponsor the Eighth Annual Postgraduate Course on Diseases of the Chest, to be held at the Bellevue-Stratford Hotel, Philadelphia, Pennsylvania, March 7-11, 1955. Tuition: $75.00.

For information write to the Executive Director, American College of Chest Physicians, 112 East Chestnut Street, Chicago 11, Illinois.

Personal and News Items

George W. Parsons, Texarkana, who has been ill for the past several months, is expected to return to this office about January first.

M. C. Hawkins, Jr., Searcy, Arkansas, attended the annual meeting of the American College of Surgeons at Atlantic City from November 15 through November 19, 1954.

W. G. Cooper and W. A. Clark, both of Little Rock, conducted a cancer clinic November 17 at DeWitt, under the auspices of the Arkansas Cancer Society.

Thomas L. Ashcraft opened his office in Rison in November. A veteran of World War II, and a graduate of the University of Arkansas Medical School, he returns from internship in Wheeling, W. Va., to his native state to engage in a general practice.

The Grand Lodge of Arkansas Masons voted $4,000.00 to the Tuberculosis Sanatorium at Booneville as a fund for medicines. Frances J. Scully, Hot Springs, was elected Grand Master at the same meeting.

John H. Delamore, formerly of Neosho, Missouri, has opened an office in Fordyce. He took offices formerly occupied by Arthur E. Parks who is moving to Richwood, West Virginia.

Alex Tharp Gillespie announces the opening of his office in Little Rock for the practice of obstetrics and gynecology December 1st.

L. H. McDaniel, Tyronza, President-elect, and R. C. Dickinson, Horatio, Immediate Past President of the Arkansas Medical Society, were delegates to the Clinical Session in Miami, Florida, in December.

Contributors to the American Medical Education Foundation From Arkansas

November, 1954

Charles W. Anderson, Pine Bluff.
M. E. Blanton, Jonesboro.
George C. Burton, El Dorado.
Cazort-Johnston Clinic, Little Rock.
A. Meryl Grasse, Calico Rock.
Cal D. Gunter, Siloam Springs.
J. D. Huskins, Siloam Springs.
Sanford C. Monroe, Pine Bluff.
A. R. Sparks, Little Rock.
Carl L. Wilson, Fort Smith.

Roger P. Edmondson, Springdale, took a 2-week refresher course in Chicago late this fall.

Loyce Hathcock, Fayetteville, and Mrs. Hathcock, returned in January from an intersectional meeting of the College of Surgeons held in Lima, Peru.

Lewis Henry, Fort Smith, took some postgraduate work in Boston during November and December.

S.M.A.

Some fifty physicians from Arkansas were registered at the Southern Medical Association meeting in St. Louis last November. The highlight of the group was probably the enthusiastic meeting of the Arkansas Alumni group which held its dinner with more than 150 guests, presided over by Louis Freidma '38, now living in Birmingham; Alumni Secretary Robert (Dusty) Rhodes, and University Provost Lewis Rohrbaugh were visitors.

Honored guests of the evening were Tom Spies, Birmingham, and Chicago; and Mr. C. P. Loranz, Birmingham, long-time secretary-general of the Southern Medical Association.

Arkansas physicians contributed considerable portions to the program at this same meeting. Original papers and discussions were presented during the 4-day session by:

Jerome Levy, Kenneth G. Jones, Horace C. Barnett, James C. Atkinson, H. Fay Jones, L. W. Fabian, P. C. Long, Cecil W. Shafer, Willis Brown, B. G. Henley, all of Little Rock, and L. H. McDaniel, Tyronza; Martin H. Hawkins, Searcy; Gerald Teasley, Texarkana; Fount Richardson, Fayetteville.

W. H. Bollinger, Charleston, was honored by the Commercial Club of that city in December as the community's "Most Valuable Citizen." He has practiced in Franklin County for 47 years, is a native of that area and attended the University of Arkansas Medical School.

Conway adopted a Hospital Bond Issue for $100,000 early in December. A new building will be constructed with a top capacity of 75 beds.

The Union County Medical Society was addressed December 7 by Bryce B. Reeves, director of the Medical Dept. of the Standard Oil Co. of Indiana.

Proceedings of Societies

The First Councilor District of the Arkansas Medical Society met Thursday, November 18, 1954, at the Hotel Noble in Jonesboro. The following officers were elected:

President—Eldon Fairley, Wilson.

Vice-President—John T. Gray, Jonesboro.

Secretary—J. H. McCurry, Cash.

SWAN WILL HEAD ASSISTANTS GROUP

Earl Bee Swan of Dover was chosen president-elect of the newly formed Arkansas Medical Assistants association during the group's initial meeting at Little Rock, November 13 and 14.

President of the new Association of Medical Technicians is Miss Charlene Hardeman of Little Rock.

The association is sponsored by the Arkansas Medical Society.

ARKANSAS UROLOGY SOCIETY

A meeting of urologists throughout the state was held on November 5, 1954, and the Arkansas Urology Society was inaugurated. There are future plans for forming a section to the Arkansas Medical Society.

Guests of the society were David Allen, resident at University Hospital, Little Rock, and Rex Boland, associated with Veterans Administration, Little Rock.

The next meeting will be held in conjunction with the Annual Arkansas Medical Society Meeting in Hot Springs.

The society elected the following officers:

H. Fay Jones, president; Gerald Teasley, vice-president; Ralph Downs, secretary-treasurer.

Ralph A. Downs, Sec'y-Treas.

Henry Hearnsberger and Bruce Ellis of Stephens, Arkansas, entertained the Ouachita County Medical Society at dinner Thursday evening, December 2, in Camden.

A symposium on "Pediatric Emergencies" was conducted by Katharine Dodd, and Norman J. Johnson, Little Rock.

The following new officers were elected:

President—W. B. Ellis, Stephens.

Vice-President—L. V. Ozment, Camden.

Secretary—R. B. Robins, Camden.

Delegate—Henry Hearnsberger, Stephens.

Alternate Delegate—John L. Dedman, Camden.

R. B. Robins, Secretary.

The Ninth Councilor District Medical Society met December 4 in Harrison. G. H. Butler, Fayetteville, presided.

The program was presented by Guy Calloway, Jr., and W. W. Wood, both of Springfield, Mo., who conjointly spoke on acute cardiac emergencies. A film on the newer drugs for cardiacs was presented by Mr. Wendell Power, courtesy Wyeth, Inc., and a new film on file at the office of the Arkansas Cancer Society, "Oral Cancer" was shown.

About 20 physicians were registered.

Ross Fowler, Secretary.

Election of officers for the Ouachita County Medical Society for 1955:

President—Bruce Ellis, Stephens.

Vice-President—L. V. Ozment, Camden.

Secretary-Treasurer—R. B. Robins, Camden (re-elected).

Delegate—Henry Hearnsberger, Camden.

Alternate Delegate—J. L. Dedman, Camden.

Washington County officers for 1955 are:

President—Max McAllister.

Vice-President—Coy C. Kaylor.

Secretary-Treasurer—Stanley Applegate (re-elected).

Delegate—G. H. Butler.

Alternate Delegate—James Stocker.

WOMAN'S AUXILIARY

Woman's Auxiliary to Jefferson County Medical Society held their November luncheon in the home of Mrs. Charles Anderson with Mrs. Ralph Wooley as co-hostess. Mrs. Ross Maynard presented a program on the "Histories of Medical Auxiliaries." Mrs. Louis Hundley, new president of the Southern Medical Auxiliary, spoke on the origin and purposes of that Auxiliary. Mrs. W. H. Bruce outlined the history and accomplishments of the Women's Auxiliary to the American Medical Association. Mrs. John Walker traced the organization and growth of the local auxiliary.

Also in November, climaxing National Nurses Week, a public tea was held at the Y.W.C.A. in honor of the nursing profession with particular recognition of Miss Blanch Tomaszewska Jefferson County's oldest registered nurse. Of special interest was a table with a display of hospital caps worn by nurses now in service at the Davis Hospital. Thirty schools of nursing were represented. There was also a nurse recruitment table, with a display of posters and leaflets.

The November luncheon meeting of the Woman's Auxiliary to the Union County Medical Society was held at the Petroleum Club in the Randolph Hotel. Hostesses for the occasion were Mrs. G. D. Murphy, Jr., Mrs. Warren Riley and Mrs. Berry Moore. The officers for the year are: Mrs. Sam G. Jameson, president; Mrs. K. R. Duzan, vice-president; Mrs. Jacob Ellis, secretary; Mrs. W. H. Handley, treasurer, and Mrs. C. D. Cyphers, historian. Mrs. Jameson announced appointment of the following chairmen of standing committees:

Civil Defense—Mrs. J. H. Pinson; Doctor's Day—Mrs. G. D. Murphy; Exhibits—Mrs. Austin Doren; Health Education — Mrs. Ted Pollard; Nurse Recruitment — Mrs. Randolph Murphy; Loan Funds—Mrs. Frank Thibault; Program—Mrs. Duzan and Mrs. George Burton; Public Relations —Mrs. Warren Riley; Legislation—Mrs. Robert Turnbow; Rural Health—Mrs. Paul G. Henley; Today's Health and Bulletin—Mrs. Gardner Landers and Mrs. David Yocum; and Auxiliary Advisory Committee—Mrs. Frank Clark, Mrs. Pinson, Mrs. Thibault, Mrs. Landers and Mrs. Moore.

Willie Oates, Publicity Chairman.

Orchids to Mrs. Louis Hundley of Pine Bluff, who was installed as president of the Women's Auxiliary to the Southern Medical Association at its November Meeting in St. Louis. Mrs. Hundley, a fluent speaker, and a gracious personality in anybody's meeting, will preside for the coming year, and at the next Association which convenes in Houston in November, 1955.

BOOK REVIEWS

Peripheral Circulation in Man: A Ciba Foundation Symposum. Editors for the Ciba Foundation: G. E. W. Wolstenholme, O.B.E., M.A., M.B., B.Ch.; and Jessie S. Freeman, M.B.; B.S., D.P.H. 219 pages, illustrated. Boston: Little, Brown and Company, 1954. Price $6.00.

This unusual little book will find a valuable place in the reference shelves of research workers in the field of circulation. It is a compendium of modern methods of the study of blood flow and in changes in the circulation due to physical and chemical agents. It is clearly written and readily comprehended, but its practical application will be found useful chiefly in schools and commercial laboratories. It is a concise compendium with a wealth of references.

Hypertension: Humoral and Neurogenic Factors: Ciba Foundation. Edited by G. E. W. Wolstenholme, O.B.E., M.A., M.B., B.Ch., and others. Little Brown and Co., Boston. Pp. 294. 1954. $6.75

This is another of the several small volumes put out by the Ciba Foundation on diseases of the cardio-vascular system. They proceed along the fundamental lines of studying disease from a basis of normal Physiology and its deviations. Much time is devoted to underlying Physiology, and these symposia are indeed a "must" for a worker in the field of experimental cardio-vascular disease. For the average reader it is a detailed refresher course in the underlying principals of vascular mechanism and can therefore be useful to all medical thinkers. Clinicians, pharmacologists, and physiologists can, alike, find something of value in the series.

Two publications of the American Cancer Society have reached the desks of Arkansas physicians in the last few weeks. These monographs are the product of skilled artisans and from the finest clinics in America, and constitute the latest developments in the recognition of cancer.

Seven of these brochures have been provided, and in each physicians library they constitute a valuable work of reference. Keep and consult them.

Handbook of Medical Treatment: Edited by Milton J. Chatton, A.B., M.D., Assistant Clinical Professor of Medicine, University of California School of Medicine, and others. Fourth Edition. Pp. 570. Lange Medical Publications. Los Altos, Calif. 1954. $3.00.

This new Fourth Edition has been largely revised and new names appear in various sections, keeping fresh the sources from which its information is drawn. It is, in every sense, a "Handbook" with an appendix filled with various "tables," normal value, etc. It includes references to the newer drugs, and gives Hospital code numbers for each disease entity. Its small size—format 4x7 inches, and limp cover facilitate its use for the coat pocket, and it constitutes one of the best of the quick-reference handbooks. The bibliography is omitted.

U. C. MEDICAL CENTER LIBRARY
FEB 25 1955
San Francisco, 22

FEBRUARY 1955

THE JOURNAL OF THE ARKANSAS MEDICAL SOCIETY

VOL. LI No. 9

FORT SMITH, ARKANSAS

79th ANNUAL SESSION ARKANSAS MEDICAL SOCIETY
ARLINGTON HOTEL — HOT SPRINGS — MAY 30-31 - JUNE 1

effective treatment and enticing treat

ILOTYCIN PEDIATRIC

(Erythromycin, Lilly) Ethyl Carbonate

another reason to consider ILOTYCIN FIRST

Lilly

for the epilepti

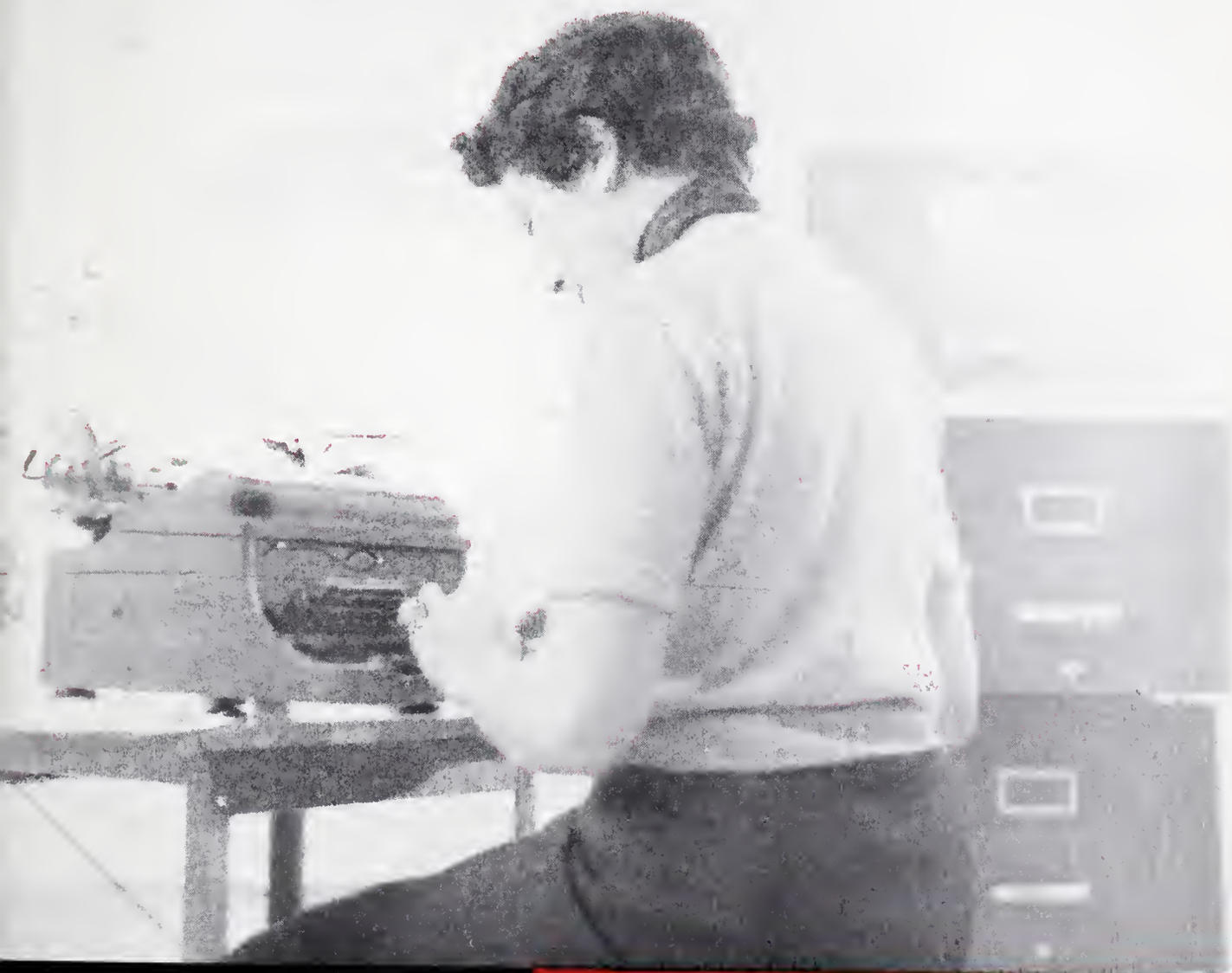
Modern diagnostic methods and effective anticonvulsants now help the patient with epilepsy enjoy greater freedom from seizures. And with a more understanding society, greater independence is assured.

DILANTIN® SODIUM (diphenylhydantoin sodium, Parke-Davis)

an established anticonvulsant of choice, alone or in combination, for control of grand mal and psychomotor seizures -- without the handicap of somnolence.

DILANTIN Sodium is supplied in a variety of forms -- including Kapseals® of 0.03 Gm. (½ gr.) and 0.1 Gm. (1½ gr.) in bottles of 100 and 1,000.

reater independence



MEDICAMENTA VERA
PD & CO.
Parke, Davis & Company
DETROIT, MICHIGAN

THE

Journal

OF THE

Arkansas Medical Society

Owned by

THE ARKANSAS MEDICAL SOCIETY

And Published Under Direction of the Council

FOUNT RICHARDSON, M.D., Editor

316 West Dickson Street Fayetteville, Arkansas

MR. PAUL C. SCHAEFER, Business Manager

215 Kelley Bldg. Fort Smith, Arkansas

The Advertising policy of this JOURNAL *is governed by the rules of the Council on Pharmacy and Chemistry of the American Medical Association.*

EXCLUSIVE PUBLICATION—Articles are accepted for publication on the conditions that they are contributed solely to this JOURNAL.

COPYRIGHT, 1955—By The JOURNAL *of the Arkansas Med-*

COPYRIGHT, 1955—By the JOURNAL *of the Arkansas Med-*

NEWS—Our readers are requested to send in items of news, also marked copies of newspapers containing matter of interest to the membership.

OFFICERS OF THE ARKANSAS MEDICAL SOCIETY

W. R. BROOKSHER, President....Fort Smith
L. H. McDANIEL, President-Elect....Tyronza
T. P. FOLTZ, First Vice-President....Fort Smith
ELDON FAIRLEY, Second Vice-President....Wilson
R. H. WHITEHEAD, SR., Third Vice-President....DeWitt
J. J. MONFORT, Secretary....Batesville
DANIEL H. AUTRY, Treasurer....Little Rock
T. DUEL BROWN, Speaker, House of Delegates....Little Rock
C. C. LONG, Vice-Speaker....Ozark
MR. PAUL C. SCHAEFER, Executive Secretary
215 Kelley Bldg., Fort Smith

COUNCILORS

First District—JOE VERSER....Harrisburg
Second District—HUGH R. EDWARDS....Searcy
Third District—J. MAX ROY....Forrest City
Fourth District—L. K. HUNDLEY, Chairman....Pine Bluff
Fifth District—D. E. WHITE....El Dorado
Sixth District—HARRY E. MURRY....Texarkana
Seventh District—H. KING WADE, JR....Hot Springs
Eighth District—H. ELVIN SHUFFIELD....Little Rock
Ninth District—FOUNT RICHARDSON....Fayetteville
Tenth District—J. M. KOLB....Clarksville

VICE-COUNCILORS

First District—WAYNE WORKMAN....Blytheville
Second District—JOHN SNEED....Conway
Third District—J. P. WILLIAMS, JR....Brinkley
Fourth District—H. W. THOMAS....Dermott
Fifth District—GEORGE BURTON....El Dorado
Sixth District—CHARLES YARBOROUGH....Texarkana
Seventh District—RANDOLPH ELLIS....Malvern
Eighth District—ROBERT D. JONES....Little Rock
Ninth District—LEE A. DEAN....Rogers
Tenth District—LOUIE A. WHITTAKER....Fort Smith

Notice on Form 3578-P to be sent to the Arkansas Medical Society, 215 Kelley Building, Fort Smith, Arkansas. Published monthly under direction of the Council, Arkansas Medical Society, at Fort Smith, Arkansas. Vol. LI, No. 9. Subscription $3.00 a year. Single copies 50 cents. Entered as second-class matter, Sept. 23, 1947, at the post office at Fort Smith, Arkansas, under the Act of Congress of March, 1879. Acceptance for mailing at special rate of postage provided for in Section 1103, Act of October 3, 1917, authorized August 1, 1918.

• SPECIAL FEATURES

Committee on Cancer Control.... 195

An Address 196

Satisfactory Management of Vasomotor Rhinitis 205

Rectal Injury 210

• FEATURES

Coming Events 212

Editorial 213

Obituary 214

Arkansas Traveling 215

Tuberculosis Abstracts 216

Personal and News Items 217

Proceedings of Societies 218

Woman's Auxiliary 219

Book Reviews 220

The JOURNAL
OF THE ARKANSAS MEDICAL SOCIETY
PUBLISHED MONTHLY UNDER DIRECTION OF THE COUNCIL

Vol. LI February, 1955 No. 9

Committee on Cancer Control

C. A. ARCHER, M.D., Chairman

MEDICATION IN TREATMENT OF CANCER

While rarely used as a primary mode of treatment, certain anti-cancer drugs are assuming a prominence as supplements to other more generally accepted plans of therapy.

Among these are nitrogen mustard and triethlyenemelamine which offer some promise in the way of prolongation of life when employed as adjuvants to roentgen therapy in the treatment of Hodgkin's disease and other lymphomas. Their use may be limited by depressive action on the hematopoietic system. Acute leukemia may be benefited in short remissions by the use of aminopterin, especially if used in conjunction with cortisone. Their use may change the course of an acute leukemiat to a subacute or chronic form in which local roentgen therapy may prove of greater value.

The survival time of patients with far-advanced cancer of the breast may be lengthened by the judicious use of hormones, testosterone and estrogens. They appear to give a "lift" to the patient's well-being and offer much in the control of pain incident to metastatic lesions. Estrogenic administration, if combined with orchidectomy, may prove of great assistance in relief of the symptoms of metastatic malignancy of the prostate.

The radioisotopes have as yet not proved themselves of special value although radiophosphorus appears to be a specific in the treatment of polycythemia vera and radiogold offers limited palliation in malignancies accompanied with pleural and periotoneal accumulation of fluid.

AN ADDRESS

W. B. HILDEBRAND, M.D.
President American Academy of General Practice

Doctors of medicine are members of a distinguished segment of the world's people. Out of some 160,000 physicians practicing private medicine in the United States today, over 100,000 are family doctors. The general practitioner of medicine constitutes less than one-tenth of one per cent of the nation's population. No other profession in the 99.9 per cent of the remaining population requires as long nor as intensive an education as does the practice of medicine. Likewise no other profession assumes as high a moral obligation and responsibility towards its fellowmen as does the medical profession.

Obtaining this distinction requires the expenditure of a great amount of time, money, and effort. Once achieved, because of the price paid, many individuals who have had the good fortune to experience this lot in life, succumb to the malignancy of complacency about their obligation to society at large, to themselves, and to the fellow members of their profession. Physicians, probably because they are fundamentally individualistic by nature, tend to sink into their own limited work-a-day world, surrounded by an aura, which in their own minds, set them aloof from their community and they become a law unto themselves.

Such an attitude on the part of the average doctor to remain aloof from civic responsibility, along with three other factors, first the oft-denied but definitely present social revolution that has taken place in the last twenty-five years of the world's history, secondly the very rapid increase in scientific knowledge producing specialization in all fields of human endeavor, and thirdly, two World Wars occurring in a quarter of a century, have presented the medical profession in America with some very perplexing, confusing, and to a large extent unsolved problems. I propose to discuss some of these problems. They are not necessarily scientific ones but might be classified as medico-economic ones, inasmuch as they all pertain to the present social and economic status of the doctor in the highly complex, difficult manner of living that we call western civilization.

Because of the fact that the problems of the family doctor are among the most important and pressing, I shall concentrate on those first and discuss later, questions involving the entire medical profession.

What are these problems?

I. **The present status and future of the general physician in the complex matrix of American Medicine.**

A. His Education.
B. His Hospital Problems.
C. His Recent Adverse Publicity.
D. His Future.

II. **Those problems affecting all physicians, including,**

A. The Veterans Administration Program.
B. The Bricker Amendment, and its implications.
C. The practice of medicine by corporations.
D. Voluntary health insurance plans.

First, the general practitioner and his problems. We might ask ourselves the question: Is the general practitioner a dying member of the medical team? Will his work in the future be performed by teams of specialists as is now done under the health insurance plan of New York City, Kaiser Permanente in California, or the Henry Ford Hospital in Detroit? Will the family doctor gradually fade away from the medical scene as we now know him, or is he on the ascendancy and is he regaining his place of former respect and esteem?

I believe that evidence in favor of the latter is unmistakable. Through the American Academy of General Practice, the organization responsible for supporting the resurgency of the general practitioner, the family physician is not only regaining his previous position but surpassing it. May I present to you some facts.

A. **What about the education of the family doctor?**

The organization of the Academy in 1947 was unquestionably the inevitable result of the clash of two forces being exerted in opposite directions on the medical scene. They were:

1. The increasing demand by the public for a greater number of well-trained family physicians.

2. The inability of the medical profession to satisfy that demand because of lack of hospital

An address by W. B. Hildebrand, President American Academy of General Practice.
Given before the Arkansas Academy of General Practice, October 6, 1954, Little Rock.

facilities for many general practitioners, and the fact that medical school teaching was departmentalized to such an extent that undergraduate teaching was psychologically tuned to specialization.

In order to obtain factual information, two study groups were set up by the Academy after its organization. They were:

1. The Commission on Education.
2. The Commission on Hospitals.

After a prolonged study the Commission on Education reported the following:

1. There was little or no emphasis on preparation for the practice of general medicine in medical schools.
2. There was little emphasis on continuation courses of study for family doctors.
3. There was little interest on an undergraduate level in choosing general practice as a career. Only two out of ten seniors out of a large survey were planning to enter general practice in 1948, the remainder going into specialties.

What has happened in the field of undergraduate and postgraduate education in seven years has changed and is currently changing the picture remarkably.

What is most important, the attitude of students is changing. Along with two other members of the American Academy of General Practice, I participated in a one hour panel discussion on general practice before the Student American Medical Association Convention in Chicago in 1953. When we were through we were deluged with questions, such as how to choose a location, how to get on a hospital staff, how did we get along with specialists, did doctors really make night calls, how much more did our malpractice insurance cost than that of the specialist because our standards of practice were unquestionably lower than that of the specialist, et cetera. Their eagerness and genuine desire to learn more about general practice was characteristic of a new intense interest in general medicine among medical students. Ninety per cent of the seniors at Michigan University recently stated that they were seriously considering general practice as a life work. Six of ten medical students throughout the country in a large survey made recently have signified their intention of entering general practice.

Such a resurgence of interest in general practice among medical students has thrown a tremendous responsibility on medical schools and educators. In many medical schools there is no adequate preparation for general practice, but the curricula is being currently altered to fit the need. For instance:

A. Bowman Gray School of Medicine of Duke University, Washington University, and Western Reserve University are changing the theory of their training with the thought in mind of implementing the undergraduate medical student to think about the economic, sociological, psychological, and environmental factors that determine whether or not medical care is qualitatively and quantitatively adequate.

B. Cornell and Pennsylvania have a new type of continuation clinic, in which the student follows the individual patient in his progress from clinic to clinic rather than working all day in one certain clinic on a certain specialty.

C. The University of Tennessee School of Medicine has a so-called "family doctor clinic," in which the teaching is done by general practitioners.

D. Boston University includes a year of family study and one month of home calls in its senior year.

E. Pennsylvania assigns each Freshman medical student to a family when he matriculates. If he is fortunate enough to remain during the next four years he follows the family as medical advisor until he graduates.

F. Twenty-one medical schools are now using the so-called preceptor plan of training by which each senior student is assigned to a general practitioner in the field for a specified time during which he lives and works with his preceptor in daily practice.

G. Fifty-four of seventy-nine medical schools have embodied in their curricula, courses in integrated medicine, meaning the diagnosis and treatment of a **patient** who is ill rather than the diagnosis and treatment of **isolated diseases** in organs, tissues or cells.

One of the most enlightening and heartening attitudes on the subject of integrated medicine to be found in the literature is seen in the November 1953 volume of the Medical Clinics of North America, in an article entitled "The Physician, The Patient and Disease" by Doctor Isadore S. Ravdin, Barton, Professor of Surgery at the University of Pennsylvania College of Medicine. I quote, "The apathy of some clinicians disturbs me. There has been an extraordinary lag in the adoption of the concept of the complete care of the patient.

"When the age of specialization came it deprived the medical student of his view of the

patient as a whole, and of medicine as a single discipline. He spent the first two years learning basic sciences in his laboratory where the patient was hardly more than a remote goal. When in his clinical years the patient finally came into view he was dismembered by the specialist into separate diseases for treatment in the hospital. The patient's continuing problems, whether organic or psychosomatic, and his continuing care over a period of months or years were hardly apparent to the medical student seeing him for a brief moment in a specialty ward or clinic. The patient had become a case as lifeless as the file that held his record." Dr. Ravdin continues, "For the past few years Deans and Faculties of several Universities have been trying to put the patient back together again, and it is hoped that this movement will be successful."

This attitude coming from an old tradition-bound medical school such as Pennsylvania is indeed heartening.

B. **Now what of postgraduate medical education?**

Because of the fact that fifty hours of study annually is a requirement for continued membership in the American Academy of General Practice, since 1947 postgraduate medical education has been riding the crest of a period of enthusiasm never before seen in this or any other country. During 1953, 66,000 physicians attended approximately 1,600 formal postgraduate courses offered throughout the United States. This is an increase of 20,000 doctors or 43 per cent over those who attended them in 1952. These figures are obtained from the Council on Medical Education and Hospitals of the American Medical Association.

It is the philosophy of the Academy that every general practitioner in the United States should be able to spend one hour per week in some type of postgraduate study, in the same spirit of financial sacrifice necessary if he were to attend a football game or go fishing or hunting. Physicians who practice in groups or who live near medical centers have no difficulty in satisfying this requirement. For the remote general practitioner in rural counties the problem is different, and many innovations in teaching aids have been devised for him.

First, in some states, traveling teams of four to six doctors stage one or two day clinics in various sections of the state. Michigan, Illinois, and Wisconsin are leaders in this type of education. Second, in Kentucky and Indiana over a state-wide telephone hookup a one to two hour medical program has been carried by private wire to county societies in outlying areas who listen in by the aid of amplifiers. As many as four hundred doctors have been reached in one night at a cost of $2 per doctor. Third, the Ohio Academy of General Practice has a large library of medical lectures on phonograph records which are rented to groups in remote areas. Fourth, a company in California is currently detailing a tape recorder and synchronized film projector and then renting out weekly tape recordings on timely medical subjects for a nominal sum to groups or individuals.

This cursory review would indicate that at the present time far greater emphasis is being placed on the general practitioner than ever before in educational circles.

Now with nearly 20,000 general practitioners fulfilling their annual postgraduate study requirements, and with increasing numbers of young, well trained graduates electing the field of general practice due probably to renewed emphasis on general practice in medical schools, and with hundreds of rural areas realizing the inestimable value of the family doctor in community life and providing modern facilities for the practice of medicine to attract and hold the young physician, the conclusion can only be drawn that the practice of modern general medicine is on the ascendancy and is rapidly regaining the lost prestige of the 1930's and early 40's.

Let us now turn to the question of the general practitioner in his relationship to the modern hospital. We can provide the public with more adequately trained family doctors and give them educational opportunities that are unlimited but this does not solve the greatest problem that faced the general practitioner in 1947 when the Academy was organized and which remains the greatest problem, that of his relationship to and privileges in hospitals.

That group of general practitioners that studied the hospital problem in 1947 found the status of the family doctor in the majority of hospitals to be rapidly deteriorating. Many hospitals were denying privileges to him. Many new hospitals were being built and staff organizations were such that all doctors except those with Board certification were being excluded. If the general practitioner was to be given less and less responsibility as on the hospital staff, and have fewer and fewer privileges in his workshop his demise seemed certain. Such a situation, that of a threatened exclusion of the general practitioner from adequate hospital facilities, was the greatest threat to the then new American Academy of

General Practice and still is a very potent one. However, many strides have been made and steps taken to correct this situation.

When the Commission on Hospitals, after its organization in 1947, had accumulated enough workable data, giving a panoramic picture of the problem throughout the country they published the first edition of a booklet called the "Manual of General Practice Departments in Hospitals."

As you doubtless know, this manual discussed the paradox of the crying need for more family doctors, and the ever increasing restrictions that were being placed on the privileges of general practitioners in hospitals throughout the country. The manual set up a blueprint for integrating the general practitioner into the hospital staff through the organization of "Departments of General Practice," which would in effect, allow the family doctor to properly care for the diagnostic and therapeutic needs of his patients.

At first the reception of such an innovation in staff organization was cool, however it was finally accepted and in 1952 when the Joint Commission on Accreditation assumed the responsibility for standards of medical care in hospitals based on the work pioneered by the American College of Surgeons, a section was added conforming to the principles of the Academy's Manual for the integration of general practice departments in hospitals. This was a great victory and long sought-for goal and its acceptance has resulted in the formation of general practice departments in nearly 50 per cent of the 4,700 odd general hospitals in the United States.

It is axiomatic that the standards of medical care in such communities served by these hospitals will be elevated because good medical care in any community cannot be provided without the physician having access to hospital facilities which are adequate.

Since hospital administrators and the medical profession now have a clear-cut statement from the Joint Commission as to the organization and operation of the general practice department, there should be no question about accreditation as far as staff organization is concerned if privileges are granted to general practitioners under the principles outlined in the manual of the Academy.

The Joint Commission on Accreditation, to most of us, is cloaked in mystery and secrecy. It should not be. Its activities should be more widely publicized. It was organized in 1952 and it is composed of six members from the American Hospital Association, six from the American Medical Association two of which are general practitioners and members of the Academy, three from the American College of Surgeons, three from the American College of Physicians, one from the Canadian Medical Association, and one from the Canadian Hospital Association. The entire program is voluntary and not a police system. The sole purpose is to raise the quality of medical care delivered by American hospitals to the public. It has not been universally accepted. The State of Florida does not recognize it at all. The Commission has set up minimum standards for accrediting and these are principles not laws. The leading principles are that the staff shall be self-governed, self-educating, and self-analytical. It must define, control and be responsible for the medical activities of the hospital.

A point system has been set up, each functional department in the hospital being given a percentage rating, one hundred being perfect. Seventy-five is necessary for complete and full accreditation, sixty to seventy-five means provisional accreditation, and less means failure of accreditation. There are eight common causes for failure to receive accreditation:

1. Fire hazards.
2. Fee splitting and unethical staff practices.
3. Evidence that non-medical practitioners are using the hospital.
4. Excessive removal of normal tissue and unnecessary surgery.
5. Lack of supervision of the clinical work done in a hospital.
6. Lack of a thorough review on a monthly basis of the clinical work done in the hospitals.
7. Lack of clinically recorded essential entries on the records to justify certain procedures being done.
8. High and unexplained morbidity and mortality rates, and a high Caesarean section rate.

Such causes for failure of accreditation illustrates the emphasis placed on the care of the patient by the Commission.

May I repeat and emphasize that the Joint Commission has approved the formation and function of a Department of General Practice into the hospital staff organization as recommended by the manual of the Academy of General Practice, and those recommendations include the stipulation that the members of the General Practice Department shall have the privileges of the clinical services of the other departments according to their demonstrated ability, skill, and

judgment. No more clear-cut statement could be made.

Just because a man secures a license to practice medicine does not mean that he is competent in all fields of medical endeavor. The greatest problem in regard to extending privileges to general practitioners has been the demand by many of them for major surgical privileges. This problem can be solved.

After a Department of General Practice has been formed in a hospital almost invariably the staff has granted such privileges to those found competent. Lack of a specialty certification does not mean that a man is not capable of performing many procedures falling under a specialist's classification.

One thing is certain, "with privilege comes responsibility." The future of the Family Doctor and the Academy rests not only on the ability of each general practitioner to stand for high quality and high standards of medical care, but to **show** and **demonstrate** to the public, the press, medical schools, hospital administrators, trustees, and our colleagues that he **does** stand for such high quality and standards.

The greatest progress will be made if no attempts are ever furthered to obtain for any physician, by pressure, friendship, or otherwise, hospital privileges that are not commensurate with his ability.

It is to be expected that many problems will arise in the process of improving medical care and in raising hospital standards. Also in the metamorphosis of hospital staff organization it is to be anticipated that some hospitals will be completely staffed with specialists, and some with only general practitioners on the staff, both completely inadequate to meet the needs of the patient.

The completely adequate well-rounded hospital staff such as is provided for in the manual of the Academy incorporates both specialists and general practitioners. It is endorsed by the A.M.A., the Joint Commission, and the American College of Physicians and looks to be the logical answer not only to the problem of the general practitioner for hospital privileges, but also to the need for better medical care.

Now to the fourth serious problem confronting American medicine, and general practitioners in particular. I refer to the deluge of very adverse publicity found in the public press in recent months, to such articles as "Too Much Unnecessary Surgery," which was an interview with Doctor Paul Hawley by the Editorial Board of the U. S. News and World Report, "Patients for Sale" by Steven Spencer of the Saturday Evening Post, "Needless Surgery" from the Reader's Digest, "Why Patients Are Mad" by Sterling Fountain in Redbook, "Unjustified Surgery" by Greer Williams in Hospitals, "Why Some Doctors Should Be in Jail" by Howard Whitman in Collier's, as well as many newspaper articles and interviews given to the press.

Certainly, one would be extremely naive if he did not realize that such a public airing of the evils said to be besetting the medical profession in its relation to the public stems from the American College of Surgeons. Let me say at the outset that I do not at all question the motive of that group. Neither do I share the belief of so many of my colleagues that greedy surgeons are openly campaigning against the rest of the medical profession, in order to further their own financial security without regard to the best interests or wishes of the public or the rest of the medical profession.

In my opinion, the campaign of open publicity, of intemperate, and undocumented charges against the family physician represents an honest but misguided attempt by the American College of Surgeons to raise the standards of surgical care for the American people.

However, certainly one can question the judgment, wisdom, and good manners of their campaign, as well as the necessity of resorting to such methods used in the attempted elevation of the surgeon at the expense of the general practitioner. The campaign is clever and an old technique is being used. It is an old trick in logic. In pointing an accusing finger at everyone else, the College of Surgeons clothes itself with a cloak of virtue and anyone who raises an objection is by association admitting guilt.

As a physician and a general practitioner, I resent very much, as do thousands of other physicians, the implication in the recent campaign that the American public must be suspicious of all M.D.'s who are not members of the American College of Surgeons. Such is insulting to the medical profession of America.

The reaction of the medical profession to all these charges against medicine in general has been mixed, but last December at the interim session of the A.M.A. the House of Delegates took a stand by passing a resolution appointing a committee of six to ascertain the facts. The Committee was ordered to perform the following tasks:

1. To study all aspects of the problem of public relations created by the adverse publicity.

2. To study the entire field of professional inter-relationships alleged in that publicity as they affect the quality and cost of medical care.

3. To investigate fully and submit recommendations to the House of Delegates of the American Medical Association.

The Committee is currently studying the problems of:

1. Fee splitting.
2. Joint billing.
3. Methods of payment of an assistant.
4. Collections and disposition of fees by a third party.
5. Commissions and rebates.
6. Ghost surgery.
7. Unethical and unnecessary surgical procedures.
8. Excessive fees.

It is hoped that out of this factual study will come data that will prove either the widespread prevalence of irregular procedures, or their infrequency. Certainly, if irregularities are found to exist it is time that the medical profession ceases protecting, and punish those who reflect discredit on the majority. But let's do it in the confines of our own house, not through public, sensational, misunderstood innuendoes and accusations through the media of the press.

Many favorable articles have been seen in recent months in various publications throughout the country with the story of the family doctors as the central theme. "The Doctor Everyone Loves" in the September issue of McCalls' Magazine is a fine pictorial story that compliments the medical profession. The July issue of Cosmopolitan carries an article entitled "Is the Family Doctor Obsolete" by David Landman that gives the American Academy of General Practice credit for the changing attitude toward general practice. "I Am a Family Doctor" by our own Dr. Francis Hodges of California in a recent issue of Collier's is without peer. These articles as well as many others all tend to counteract our recent unfavorable publicity.

Has the American Academy of General Practice in its seven short years of existence solved all of the problems of the family doctor? Certainly not. The present status of the family doctor can be compared to the problems of the present Republican Administration after a short time in office. When Congress adjourned in August 1953 after its first session under Eisenhower, a reporter asked him how he felt about the work done. President Eisenhower replied: "I know of no official in the Administration so foolish as to believe that we who in January came to Washington have seen and conquered all the problems of the Nation. The future, both immediate and distant, remains full of trials and hazards. The end of our staggering economic burden is not yet in sight. The end of the peril to peace is not nearly in view."

Applying these beautifully spoken words to general practice, certainly no officer of the American Academy of General Practice is foolish enough to believe that all the problems facing that branch of medicine have been conquered. However, by its own boot straps general practice is lifting itself up and back into its proper place in the medical economy. The family physician fills a need that only he is able to fill, and at all costs this need must be satisfied.

There is no other answer to the riddle of the future of general practice than to say that there have been unmistakable signs of a renaissance since the American Academy of General Practice appeared on the medical scene seven years ago. Renewed interest in general practice on an undergraduate level, the trend in post-graduate medical education to concentrate on the needs of the family physician, the fight for hospital privileges for qualified general practitioners, and the growing awareness shown by the consuming medical public of the need for the personal physician in community life all point towards smoother highways for the general practitioner in the years ahead.

There are those, however, who entirely disagree with the philosophy of general practice as exemplified by the Academy. Typical of such a digressing philosophy, is Dr. Russell Lee, President of the Palo Alto Clinic and Professor of Medicine, Leland Stanford University Medical School, Member of the House of Delegates of the American Medical Association, and member of President Truman's Commission to study the needs of the nation's health. He said in a recent speech in St. Paul, Minnesota—I quote, "My own idea for the personal physician is that he should be an internist, being an internist myself. The general practitioner has occupied this position in the past and has occupied it well and honorably but times have changed. What is required now is an internist who understands all the ramifications of medicine, who has points of contacts with all the other specialists, who is particularly trained in

diagnosis and who has a good deal of psychiatric insight.

"This personal physician should be associated with a group of specialists covering the whole spectrum of modern medicine. It is quite impossible for any one doctor to encompass all the knowledge that is necessary for the care of the ordinary American family.

"For instance, babies should be delivered by obstetricians. The difference in maternal mortality when that is achieved is demonstrable. In areas of this country where there is good obstetrical care available, there is practically no maternal mortality.

"All children in the early years of their lives should be under the care of a pediatrician. The difference in infant and child mortality when pediatricians have care of children is striking. I happen to be from an area where practically every child is cared for by a certified pediatrician. Child mortality in our town of Palo Alto, California, for other than accidents is practically zero. There is almost no infant or child death except for certain diseases that are completely non-preventable.

"Surgery should be done by trained surgeons and not by general practitioners who do it on the side. General practitioners may do some things well but we have plenty of trained surgeons."

No comment on this is necessary except to say that Dr. Lee's views are currently shared by many prominent doctors and medical educators. Greater efforts and vigilance will be necessary in the future if we are to counteract this type of philosophy of the practice of medicine. Failure to produce a positive answer to men like Dr. Russell Lee will mean the end of general practice as we now know it.

In summarizing the first portion of these remarks, may I state that the American Academy of General Practice cannot alone be expected to attract, educate, and distribute young doctors of medicine in the field of general practice, nor can it alone provide facilities for continuing education or procure hospital staff appointments with individually appraised privileges for these young doctors. Such problems can only be solved by the entire medical profession working together. It is, however, encouraging and heartening to watch the ever widening vista of the programs of State Medical Societies, Medical Schools and the American Medical Association, all focused on the fulfillment of these vital ends.

Now, in the short time remaining let me rapidly cover three or four other pressing problems facing medicine today. The first of these problems is that of the medical care currently being given by the Veterans Administration. By means of an expanding system of free medical care for illness of any kind to Veterans and their dependents, the tentacles of Socialized Medicine are slowly but inexorably encircling a people who do not want it. Forty per cent of our male population have already served in the Armed Forces, and thus become eligible to utilize the 120,000 beds in 169 hospitals built for veterans in this country. The Veterans Administration is currently treating 100,000 bed patients and countless out-patients per day, and of those the illnesses of 85 per cent have no connection whatsoever with military service.

As the present generation of veterans grows older, geriatric and domiciliary care will require more and more beds. The natural sympathy of a grateful people following World War II was responsible for the enthusiasm of this free medical care stampede, but it is now being nurtured by political lobbies who neither represent nor control the veteran's vote. These same groups are continuing to lobby for increased medical benefits for wives and children of veterans.

Certainly, we of the medical profession have and always will endorse the principle of unlimited care for service connected illness and disabilities, as we endorse Federal care of neuropsychiatric and tuberculosis patients who are unable to pay. But, in the name of heaven why should we provide a lifetime of free medical service for illness of any kind just because a citizen has spent some time in a military training camp?

Certainly, the time has come when we must have a clear-cut definition of our country's obligations to its veterans of the future. The American Medical Association is currently doing its best to educate and alert the members of the medical profession to an immediate need for the revision of the present policy of the Veterans Administration. If the present policy is not revised then surely Governmental control of medicine through the sprawling Veterans Administration system can only be a matter of time.

The philosophy of the Bricker Amendment and its implication upon the medical profession should certainly occupy some of our consideration these days. As you know, early in 1953 Senator Bricker of Ohio along with 63 other Congressional cosponsors recommended by resolution the adoption of an amendment to our Constitution, which would limit the treaty making authority of the Economic Branch of the Federal Government and

thus protect the lives and interests of our citizens and our states. Treaties now made by our Executive Branch can become the supreme law of the land, if ratified by two-thirds of the Senate present and voting.

American medicine is vitally interested because of the existing United States "friendship treaties," and because of the covenant and contracts of the International Labor Organization sponsored by the United Nations, which if properly ratified could change our domestic laws. One of these so-called friendship treaties, called for and has resulted in an exchange of professional men between the United States and other participating foreign countries, regardless of the scientific standards of those countries or of the professional men. Had this treaty been ratified as originally written it would have overridden the requirements of many of our State licensing boards. In addition, the International Labor Organization adopted a covenant in 1952 known as "Minimum Standards of Social Security," packed with socialistic medical proposals, which if ratified by our Congress, would definitely and unquestionably establish Governmental control in medicine.

It might be well to point out here that in 1950 and '51, 2,072 graduates of foreign medical schools were interning in approved hospitals in the United States. In 1951-52 the figure grew to 3,349; in 1952-53 it was 4,388 and in 1953-54 it is currently 5,589. Ninety per cent of these foreign graduates are non-English speaking. At the present time 64 per cent of the interns in approved hospitals in the state of New Jersey fall into this category. Only one of five of these foreigners from schools which, in many instances, are not approved by the Council on Medical Education and Hospitals passed the National Board of Medical Examiners examination after three to five years in our hospitals.

In many instances, these men are returning to their countries after having spent internships and residences in this country and have immediately applied for re-entry into this country under the immigration quota. Many of them are gaining admission and setting up practice. This procedure, if allowed to continue and grow as statistically it appears to be doing, can only result in lowering the standards of medical care.

The Bricker Amendment was defeated, but the basic issue is not dead. As doctors, because of the dangers not only to our profession but to the welfare of our country in general, we must support other proposals made which will surely evolve in the future, that will effectively plug what appears to be a loophole in our Constitution.

Thirdly, let us consider the panel system of the practice of medicine. I refer here to such groups as the Health Insurance Plan of New York, Kaiser-Permanente, Henry Ford Hospital in Detroit, et cetera. Involved in such corporation practice are the principles of lack of freedom of choice of physician, the question of how efficient such panel practice is, control of medicine by non-professional personnel, et cetera. Such systems as these as is true with the Veterans Administration could be moved into Washington overnight and controlled by a national medical czar.

Whether such systems are here to stay and whether they will increase is unknown. I sincerely hope not. Three million people are currently covered under such systems. Health Insurance Plan of New York has moved 400,000 patients into 30 medical groups, served by 950 doctors.

Labor Unions have plans which are just as ambitious as the above named corporation. The San Francisco Labor Council, not a single union but 141 local American Federation of Labor unions with 187,000 members, and 300,000 dependents has recently approved a program which may have far-reaching effects on medical practice in cities the country over. The program would involve the construction of Labor Health Centers to cost up to $400,000 each, to provide comprehensive medical care of all types including home, office, and hospital, and all preventive services to all members and dependents, comprising over 50 per cent of the entire population of the City of San Francisco. The entire pineapple industry of the Territory of Hawaii has recently been organized into a group based on the health insurance plan of New York. In fact, the Medical Director of the Health Insurance Plan of New York was loaned to the group in Hawaii, in order that he might advise them on the mechanics of organization. The City of Milwaukee has recently begun a plan with one of its sponsors being Arthur Altmeyer, one of the old Social Security crowd under Oscar Ewing of the Truman Administration days. Many other such plans are apparently under way throughout the entire country.

Every doctor in the United States must be alerted to the terrific impact on private practice and freedom of choice of physician that these plans entail, yes, even the threat of the complete extinction of the private practice of medicine as we now know it. If these plans are sound, they are bound to expand. If not, they will fall under

the impact of their own mistakes. This problem over the next few years should bear the closest observation by all organized medical groups and every individual physician in this country.

The fourth and last problem is that associated with voluntary prepaid medical care plans. In this complex field of medical economics, the public and the medical profession are moving rapidly toward a crisis. More members of voluntary health plans are being hospitalized daily. In 1941 one in ten was hospitalized, in 1953 one in seven. 91,000,000 people in this country now carry hospitalization insurance. 73,000,000 carry surgical insurance, 45,000,000 are insured in Blue Cross alone, 36,000,000 carry medical care insurance, 25,000,000 have Blue Shield coverage. All of this tremendous coverage has been achieved since 1940. Blue Cross enrollment is increasing at a rate of 5,000,000 per year, and commercial carriers are exceeding even that rate. The acceptance of the voluntary principle as applied to sickness insurance has been the most rapid and complete in the history of the institution of insurance in America.

However, those hospitalized under such plans are now being given more service and hospital costs are rising at the rate of 1 per cent per month. All this adds up to a growing utilization of health plans up to the limit of coverage by the patient, as well as improper and unnecessary utilization by the physician. On a single day in one well-known 185 bed hospital a study was made. Here is what was found. Twenty-five patients who were in the hospital and who had been there for more than two weeks or longer were studied. Of those, 19 were covered under Blue Cross. Of those 19, 16 were ambulatory and could have been sent home. Five were in casts and were waiting for X-rays or cast changes to be done ten days later. Three were diabetics well controlled. One was an 80-year-old man who had been put in the hospital so his family could celebrate Christmas without him. Ten had orders that would allow them week-end leaves from the hospital. On the day that the Trustees made the results of the study known to the Staff, fifteen patients were discharged out of the 25 under study.

These practices are not confined alone to that hospital. Similar studies show that they exist all over the country. It is a basic economic fact that the greater the utilization the greater the cost of premiums in any insurance plan. How far then can we go?

Therefore, the greater the abuse, the higher the premium, resulting in an endless process, which like previous problems discussed, can result only in Government control of medical care if such abuse is not abolished. When the consuming public throws up its hands and says that it can no longer afford medical care under a voluntary system of health insurance, at that very moment the Federal Government will step in.

Doctors alone are not responsible for creating such a situation. Many factors are contributing to the abuse. The important point is that doctors alone can save it. By educating our colleagues to the grave danger, by working through County and State Societies, and hospital staffs, we can police our own ranks and get back to a sane, judicious use of voluntary health insurance. The institution of voluntary prepaid health plans unfettered by government interference is the most potent road block in the pathway of Socialized Medicine. Let us preserve it at all costs.

Time is running out. I have not had time to discuss the problem of Osteopathy and Chiropractic, the over-all problem of medical education, Eisenhower's Health and Welfare Program, public relations in modern medicine, the lack of equitable physician distribution in this country, the problem of the care of the low income patient, the shortage of nurses, the financial problems of medical schools, et cetera. These are present and deserve our sound thinking and positive action.

It has not been my intention to present to you a dismal picture of the general practice of medicine in 1954. We may liken the practice of medicine to government under a democracy. As bad as a democracy can get at certain times, it is far better than any other form of government that has been devised to date. Likewise as pessimistic as we are about the present status and future of American medicine, it is by far the best system in the world, but here is the important thing—we can make it better. The challenge is present. No one of us can meet it alone, but our individual responsibility is crystal clear. Any doctor who fails in these trying times to participate in and foster medical activities on the level of his County Society or his constituent chapter of the American Academy of General Practice is derelict in his duties to himself and to his chosen profession. But in that participation each must bear a part of the burden of the responsibility. The pleasure derived from serving the medical profession by contributing to the high purposes of our calling far outweighs the price paid in time,

money, and effort. Through such service, problems can and will be solved.

I should like to thank each of you for the warm cordiality of your welcome to me today. It is deeply appreciated. In closing may I turn from the socio-economic aspect of medicine to the philosophical side, and leave with you a few words of inspiration from the pen of Scarlet as he wrote of the great Sir William Osler. He said, "As men of medicine, we must have respect for man, personal integrity, the virtue of work, the dignity of our profession, deep interest in the craft as a high adventure and an imaginative art, all crowned by Osler's more intimate prescribed qualities, the art of detachment, the virtue of method, the quality of thoroughness, and the grace of humility. These are the things which have given our calling its strength, and which have made it one of the activities of the human spirit which has brought man out of the original darkness.

SATISFACTORY MANAGEMENT OF VASOMOTOR RHINITIS

H. A. (TED) BAILEY

Satisfactory management of the chronic stuffy nose is an everyday problem to the busy rhinologist and a not infrequent one for the general practitioner. Many of these patients regularly use some form of a local vasoconstrictor in an attempt to get relief from their nasal stuffiness. The continued use of these locally applied drugs often cause a rhinitis medicamentosa in which case simple removal of the offending drug may be all that is necessary to get satisfactory relief. In a few cases a deviated nasal septum may be the causative factor, however the large majority of the cases presenting the chronic stuffy nose have no deflected septum, nor sinusitis, and no intranasal infection but rather just a boggy swelling of the mucous membrane lining the nose and covered by a mucous secretion of varying consistency.

The color of the nasal mucosa varies so markedly from one patient to another that little significance can be attached to it. However we do find the membranes most often a pale blue color.

This condition of the nose characterized by a swollen mucous membrane producing nasal stuffiness and accompanied by sneezing and a watery mucous drainage is called Vasomotor Rhinitis. We of course know that there are many different specific causes of this condition but they are all grouped under the general term Vasomotor Rhinitis because they all produce their symptoms by causing a disturbance of the vasomotor control of the nasal mucosa.

The problem in these cases has been not only the usual difficult time we've had in actually determining the exact cause in each individual case but also correction of the disturbance after we have established the cause. The rhinologist must have an understanding of the intimate relationship of the nasal mucosa to the rest of the body and be even more aware of the general conditions producing these nasal disturbances than the internist if he is to insure proper diagnosis and management.

Many causes have been ascribed to Vasomotor Rhinitis of which the most common single cause is nasal allergy. Certainly both seasonal and perennial type nasal allergies do constitute a large number of these cases. The seasonal hay fever is more easily diagnosed by history, cytological studies of the nasal secretions and skin tests than the perennial and ordinarily responds better to both medical treatment and hyposensitization. Avoidance therapy while helpful is difficult to carry out. In cases of perennial allergies the most common allergen is house dust and it is here that avoidance therapy in all phases of living can play a big part in control of symptoms. Preparation of a dust free bedroom is especially beneficial and practical, for a patient spends approximately one-third of his life in his bedroom. Air-conditioning in the bedroom and office is also beneficial for it affords filtered air.

Nasal allergy is frequently complicated by nasal polyps. Simple removal of these polyps by a nasal snare may give mild to marked relief from nasal obstruction. We are now using a hot wire snare off of a Cameron Radio-Cautery Unit and it of course cauterizes as it removes the polyps, which does away with bleeding and obviates the need of using packing after the polypectomy. Also the need for hospitalization is avoided unless the patient requires heavy pre-medication prior to surgical removal because of emotional instability.

Not infrequently we find polyps in the nose to

Read before the Seventy-eighth Annual Session, Arkansas Medical Society, Fort Smith, April 20, 1954.

be secondary to a sinus infection which is on a bacterial basis alone. Here usually simple removal of the polyps and conservative medical and/or surgical treatment directed toward the sinusitis clear the patient's stuffy nose.

Many investigators feel that physical allergies to such factors as heat, cold, and changes in barometric pressure play a much more important role in production of Vasomotor Rhinitis than is generally accepted. Certainly we all see patients that seem to fall into this group but proving this etiologic factor is difficult.

Another cause is endocrine imbalance as seen especially with hypothyroidism and those disturbances of the gonads noted in association with menstruation, the menopause and especially pregnancy. A stuffy blocked up nose during each menstrual period is common to many women. The term Rhinitis of Pregnancy has been used to describe the stuffy, stopped up nose that is so frequently seen in women during pregnancy especially during the last trimester. This condition clears up following termination of the pregnancy. Hormone therapy during the menopause is usually all that is necessary for these cases of Vasomotor Rhinitis secondary to this imbalance.

Irritating fumes or gases may produce the "stuffy nose." This often is an occupational hazard from which avoidance is difficult or impossible without a change in work. This special type has been in the past called Hyperesthetic Rhinitis.

Emotional factors such as fear, anxiety, worry, conflict, frustration, hostility, resentment and other emotional influences are recognized as common factors in production of what many years ago rhinologists called "nervous rhinorrhea" and what today we include under the general terminology Vasomotor Rhinitis. Psychotherapy by the rhinologist or the psychiatrist is extremely important and symptomatic relief may be expected of the nasal and the other varied complaints. Still other factors are often mentioned by most investigators but their proof of these is inadequate.

Proper management of Vasomotor Rhinitis ideally depends on a careful history and clinical examination, considering the whole patient and not just his nose, followed whenever possible by the removal or correction of the causative factor. It becomes obvious that proper handling of some of the cases of Vasomotor Rhinitis may call for consultation with the allergist, the psychiatrist and the endocrinologist or gynecologist.

Unfortunately in most of the cases of Vasomotor Rhinitis we cannot determine the cause of the vasomotor instability and thus treatment must be empiric directed simply at relief of the patient's symptoms. Through the years many forms of non-specific medical and intranasal treatment have been used to obtain symptomatic relief from the nasal symptoms.

Probably the most used medical treatment has been the use of oral vasoconstrictors such as ephedrine, often combined with a barbiturate and minute dose of atropine. I have found a combination used by Dr. A. Proetz of St. Louis to be a very satisfactory oral vasoconstrictor. It is:

Ephedrine gr. 1/4, Seconal[R] gr. 1/4,
Atropine gr. 1/600

For the last few years we have had the antihistaminic drugs which have been used in allergic forms of Vasomotor Rhinitis with varying degrees of success. The most successful type treated have been those caused by seasonal allergens, with some degree of relief being obtained by upwards of 90 per cent of the patients. Roughly 50 per cent to 70 per cent of the perennial forms of allergic rhinitis seem to receive some help from the use of the antihistamines. One should remember that there are four different chemical groups from which all of our present antihistamines are derived and that because of these structural differences, a patient may fail to get relief from a derivative of one group and yet be helped by an antihistamine derived from one of the other three chemically different groups. Thus we must be familiar with the four different groups and know a representative number of antihistamines belonging to each group; for if a patient fails to respond to one member of a group he ordinarily will fail to respond to all other members of that same group, so a derivative of one of the other three groups must be chosen for further trials. The antihistamines are derived from the following four chemical compounds: Ethanolomine, Ethylene Diamine, Phenyl-propylamine, and Pyridinelene. Representatives of the first group are Benadryl[R] and Decapryn[R]; of the second are Histadyl[R], Phenergan[R], Pyribenzamine[R], Neohetramine[R], Antergan[R], Diatrine[R], and Antistine[R]; of the third Chlor-Trimeton[R]; and of the fourth Thephorin[R]. These are but a representative number of the many members of these groups that have flooded the market in the last five years or so.

Many of these drugs carry with them some side reactions produced by therapeutic doses of the drugs. They involve most frequently the central nervous system or the gastro-intestinal tract, producing commonly seen symptoms such as drowsiness and dizziness, headaches, dry mouth and oc-

casional vomiting and diarrhea. While the side reactions produced are usually the same for certain drugs one can never be certain how it will affect any one individual except by trial. With only slight effort on the part of the physician he can often use the side reactions to the benefit of his patient. Example: Giving an antihistamine producing drowsiness at bedtime only.

It should be again emphasized here that use of the antihistaminic drugs is only symptomatic treatment and not in any way curative. Thus it should be only used as adjunctive therapy.

In the past many, many forms of empiric intranasal treatments have been tried and used in an effort to find a satisfactory method of shrinking the puffy, swollen nasal mucosa. To mention a few: Simple excision of parts of the turbinates, scarification of the turbinates with knives, X-ray therapy, chemicals such as Chromic Acid, Tri-Chloroacetic Acid, Phenol and strong solutions of $AGNO_3$, applied to the nasal mucosa as cauterants to produce nasal shrinkage. Injection of escharotics such as Sodium Psylliate, Sodium Morrhuate and strong saline solutions have all been tried and with some success but the area of injection is hard to control. Various forms of cautery treatment, of which galvanocautery apparently has been the simplest and thus the most popular, have been used. A type of cautery treatment however that has been successfully reported by several writers through the years and yet has failed to become popular is submucosal electro-coagulation. I think the difficulty in establishing a technique initially must have been a factor in preventing more popular acceptance of this form of coagulation therapy. I have used this form of treatment for the last five years with such increasing success that I no longer dread the cases of Vasomotor Rhinitis for I now feel I can, in most cases, offer them satisfactory relief from their nasal symptoms regardless of the cause of their Vasomotor Rhinitis.

To understand the rationale in using this method of treatment let us briefly review certain known facts. The lower half of the nasal fossae may be completely filled by the swollen inferior turbinate in cases of Vasomotor Rhinitis. The middle turbinate is less frequently seen to be swollen and playing a part in real nasal obstruction. The soft part of the inferior turbinate on cross section is seen to be composed of dilated blood spaces covered by a ciliated pseudostratified columnar epithelium. These are cavernous type blood spaces and this tissue actually represents true erectile type tissue. This condition of chronic swollen nasal mucosa has thus been called by others chronic priapism of the nose. These blood spaces help to warm and moisten the inspired air. However, as a result of the loss of the vasomotor stability the blood spaces are increased in size and the turbinates are engorged with blood producing obstruction, while the glands present are overactive producing excessive mucous drainage.

As previously mentioned the respiratory epithelium lining of the nose is ciliated pseudostratified columnar epithelium **except** for roughly the upper one-third of the nose which is lined by a special olfactory epithelium for the reception of smell.

In certain localized areas, however, metaplasia to a strat. squamous epithelium occurs as a result of irritation from direct air currents such as often noted on the anterior tip of the inferior and often the middle turbinates. We know and recognize the importance of the cilia and the mucous blanket which covers the cilia and nasal lining. We know that this mucous blanket is the first line of defense of the body against incoming organisms and that the cilia are necessary to keep this mucous blanket moving constantly to the throat out of the nose. Here it is swallowed and destroyed by the acid of the stomach.

It was with this knowledge of proper nasal physiology that I originally accepted submucosal electro-coagulation as the proper method of turbinate coagulation therapy, as it is carried out with only minimal destruction of the overlying ciliated epithelium; but only because of constantly improving success have I continued to use it.

My first introduction to this procedure was in New Orleans during my residency. I saw a man fly some 1,000 miles round trip to have submucosal electro-coagulation carried out on his remaining turbinate following treatment of one inferior turbinate two weeks before, because he had experienced such dramatic relief from a nasal blockage of several years duration. I was particularly impressed for this man stated he had been to a number of leading rhinologists without ever receiving any **real** relief, though he had received **extensive** studies.

During the first three years by trial and error I was able to establish the following technique which I have routinely followed for the last two years and found to be quite satisfactory:

The inferior turbinate is sprayed with a 2 per cent Pontecaine solution being sure **not** to precede it with any vasoconstricting agent. Reactions are guarded against by having the patient

ACH

ACHROMYCIN has proved effective against:

Pharyngitis
Acute Bronchitis
Tonsillitis
Pertussis
Otitis Media
Scarlet Fever
Osteomyelitis
Epidermal Abscesses
Acute Brucellosis
Pancreatic Fibrosis
Typhus Fever
Sinusitis
Gonorrhea
Bacillary Dysentery
Pneumonia with or without Bacteremia
Bronchopulmonary Infection
Acute Pyelonephritis
Chronic Pyelonephritis
Mixed Bacterial Infections
Soft Tissue Infections
Staphylococcal Septicemia
Pneumonoccal Septicemia
Urogenital Tract Infections
Acute Extraintestinal Amebic Infections
Intestinal Amebic Infections
Subacute Bacterial Endocarditis

ROMYCIN*

HYDROCHLORIDE
Tetracycline HCl *Lederle*

A TRULY BROAD-SPECTRUM ANTIBIOTIC

Clinical research has proved ACHROMYCIN to be effective against more than a score of different infections, including those caused by Gram-positive and Gram-negative bacteria, rickettsia, certain viruses and protozoa.

In addition to its true broad-spectrum activity, ACHROMYCIN provides more rapid diffusion than certain other antibiotics, prompt control of infection, and the distinct advantage of being well tolerated by most persons, young and old alike.

ACHROMYCIN, in its many forms, was accepted by the medical profession in an amazingly short time. Each day more and more prescriptions for ACHROMYCIN are being written when a broad-spectrum antibiotic is indicated.

Lederle LEDERLE LABORATORIES DIVISION *AMERICAN Cyanamid COMPANY* Pearl River, New York

*REG. U.S. PAT. OFF.

tilt his head forward immediately after spraying so as to allow the excess solution to drain out of the nose on his Kleenex. After waiting a minimum of three minutes a small cotton tampon with 2 per cent Pontecaine with all excess solution expressed from it, is inserted in the nose being applied to the medial surface of the inferior turbinate. Allow this to remain a minimum of five minutes before removal being watchful of the patient so as to avoid any possible drug reaction. (Note: I have had not one even minor drug reaction following the above routine—the important feature being avoidance of any excess drug.)

Now we are ready for the actual submucosal electro-coagulation. Using the bipolartwin needles from a Birtcher Hyfrecator with the plugs in the green outlets and the setting of the control dial at 25, the needles are inserted into the anterior tip of the inferior turbinate not too close to the bone and yet well beneath the surface of the mucosal lining. This explains why no vasoconstricting agent should be used prior to the Pontecaine and why Cocaine shouldn't be used as Cocaine has a vasoconstrictor action. If the turbinates are shrunk down by a vasoconstrictor it is difficult to place the needles in the center of the turbinate body and get good coagulation of the blood spaces without producing coagulation of the overlying ciliated epithelium and interruption of its physiologic processes.

The needles are inserted approximately one and one-half inches into the inferior turbinate bodies paralleling the turbinate and then, watching the turbinate where the needles are seen entering the body, the foot switch is pressed on an average of a count of four seconds. This is then interrupted and then repeated for four seconds or less should patient discomfort be produced by the heat of the current. We continue coagulation until the area between the needles is pretty well white, then slowly removing the needles the current is cut off and on for counts of one or two. There is always momentary bleeding from the holes left by the needles but a small dry cotton tampon immediately inserted into the nose controls the bleeding and in five minutes there is no further bleeding and none will result at a later date if coagulation has been properly carried out without involving the overlying mucosa except at the point of entrance of the twin needles. Reinsertion of the needles farther back in the turbinate is occasionally necessary to open the nose but ordinarily coagulation of the anterior two-thirds is all that is needed to give relief. Only one side is done at a time with a ten to fourteen day interval. The only instructions necessary following this procedure is to keep the nostril and tip of the turbinate well greased with white vaseline until it is rechecked in ten to fourteen days. Following the above mentioned technique I have not seen a single nose bleed of any consequence and at no time has a bony slough occurred, as has been reported by other writers. Occasionally the side of the nose just treated may be blocked for two or three days as a reaction to the cauterization but as a rule this does not occur.

The following data has been obtained from 100 consecutive cases of Vasomotor Rhinitis treated by myself or my associate, Dr. Paul L. Mahoney. They all received submucosal electro-coagulation of the inferior turbinates, using the previously described technique.

Of the 100 cases in this series, 58 were female and 42 were male. The youngest was 13 and the oldest was 69. Younger patients were seen but not included because we did not carry out coagulation therapy. They no doubt would have benefited, but it was felt that they were not emotionally suited for such treatment.

11 were from 13 to 20
24 were from 20 to 30
30 were from 30 to 40
16 were from 40 to 50
17 were from 50 to 60
2 were from 60 to 70

It is obvious that the large majority of these cases occur during the period from puberty to the menopausal age.

Ten of the cases were complicated by sinusitis. Seven were bilateral and three were unilateral. Six out of the seven of the bilateral cases cleared on simple medical management combined with sinus irrigations as needed. Two of the three unilateral cases also cleared under similar management. The resistant cases of bilateral and unilateral sinusitis were subjected to naso-antral windows and immediately cleared. In all these ten cases, however, the patient continued to have nasal blockage from their Vasomotor Rhinitis despite their cleared sinus infection and it wasn't until the inferior turbinates were hyfrecated that subjective relief was satisfactory. Allergy was considered a factor in all of the cases of bilateral sinusitis.

Twelve cases had polyps. Ten occurred bilaterally and two were unilateral. Of the ten cases with polyps occurring bilaterally, nasal allergy was confirmed by cytological studies and skin tests in eight cases and strongly suspected in the other two. Four of the bilateral cases were complicated

by sinusitis so definitive treatment was simultaneously carried out. Surgery in the form of antral windows was performed on three of the latter four patients. The unilateral polyps were felt to all be infectious in origin and one case had a thickened lining membrane of the antral sinus on the same side. This latter case was managed by a naso-antral window in addition to polyps removal and bilateral electro-coagulation therapy of the inferior turbinate. All the other cases had polyp removal via the hot nasal snare, in the office, followed by electro-coagulation treatment and then referral to an allergist for specific anti-allergic treatment in all ten of the bilateral cases. We referred these patients to the allergist so that treatment of the cause could be carried out but in all cases definite improvement was already realized from the empiric treatment to the turbinates combined with careful polyp removal.

Eleven other cases gave strongly positive allergic histories and/or positive nasal smears and skin tests. These all received bilateral treatment to the inferior turbinates and were then referred to the allergist for specific treatment. This group all claimed improvement following treatment but only five (5) were relieved to the point of satisfaction. Medical treatment with the antihistamines gave the greatest help in this group, which was fortunate for it was most needed here. The aid gained from the addition of antihistamine therapy pushed the number satisfied in this group to eight.

Three cases had had prior submucous resection to relieve their nasal stuffiness but had received only partial relief. They had returned for further treatment, and examination revealed that nasal blockage was primarily from the boggy inferior turbinates. Electro-coagulation therapy to these turbinates again gave immediate satisfactory relief from the nasal blockage. Eleven more cases were seen in which we felt a deviated septum was a contributing factor to the condition and thus we did a Submucous Resection followed again by coagulation therapy. We obtained satisfactory relief in every case! Having the addition of proper turbinate shrinkage added to our armentarium makes it possible for us to offer satisfactory results to this group after septum surgery where before we could promise only partial help.

One patient had a definite clinical picture of hypothyroidism to account for her boggy swollen nasal mucosa and the Basal Metabolism Rate, which is a fairly reliable index of hypothyroid states, showed a minus twenty-four. Subsequent thyroid therapy gave marked general improvement plus continued relief from the nasal congestion. Continued relief, for on her first visit she had obtained immediate relief following hyfrecation of the inferior turbinates.

Three (3) cases were ascribed to Rhinitis of Pregnancy and given satisfactory relief by coagulation therapy alone. Seven (7) patients showed definite psychoneurotic tendencies and all of them may have had their Vasomotor Rhinitis produced by their nervous tension. However, following their treatment by the hyfrecator and at the same time trying to give them reassurances, all of these people were relieved of their nasal stuffiness. It was also suggested to these people that they consult their family physician as to further aid with their nervous tendencies.

That left a group of forty-two (42) cases in which no causative or contributing factor could be definitely determined. These were all treated by simple submucosal electro-coagulation of the inferior turbinates and relief was quick and lasting in all but three (3) of this group. In the three (3) denying improvement there appeared to be increased breathing space despite lack of subjective relief. All of these 100 patients were told to return should their symptoms recur and so far only three (3) have returned. All three were cases of seasonal allergy not getting specific desensitizations as previously advised. The time period that the latter three cases were free of symptoms varied from six (6) to nine (9) months.

Conclusion

Satisfactory management of Vasomotor Rhinitis is obtained by proper diagnosis whenever possible of the causative or contributing factors followed by their correction or removal combined with submucosal electro-coagulation therapy to the inferior turbinates. Unfortunately accurate diagnosis is not possible in approximately half of these cases and it is particularly in this group of cases that the use of proper coagulation therapy can be of so much help!

In a series of one hundred (100) consecutive cases of Vasomotor Rhinitis seen by myself or my associate, Dr. Mahoney, and followed for a minimum of three (3) months and a maximum of fifteen (15) months, we found the following: Using submucosal electro-coagulation therapy in combination with definitive treatment gave satisfactory subjective relief to fifty-five (55) cases (or 94 per cent) of fifty-eight (58) treated. Using only the coagulation treatment in cases where the etiologic factor could not be found, satisfactory relief was obtained in thirty-nine (39) or 93 per cent of forty-two (42) cases so treated.

The overall results with our present method of management of Vasomotor Rhinitis, as seen in this series of one hundred (100) cases, is satisfactory relief in ninety-four (94) or 94 per cent of the one hundred (100) cases in this series followed from three (3) to fifteen (15) months. Only three (3) of the cases have returned with recurrence of nasal stuffiness during the fifteen (15) month period required for this series of cases. All three of these returnees were cases of seasonal allergy who had had relief for six to nine months but none had gone to the allergist as advised, for specific desensitization.

BIBLIOGRAPHY

1. Beck, Joseph C.: Pathology and Intramural Electrocoagulation of the Inferior Turbinate. Tr. Am. Laryn. Rhinol. and Otol. Soc. Inc., pp. 252-266, 1930.
2. Richardson, John R.: Turbinate Treatment in Vasomotor Rhinitis. Laryngoscope, pp. 834-847, August, 1948.
3. McBean, James B.: Management of Vasomotor Rhinitis. Collected Papers of the Mayo Clinic, pp. 362-365, 1951.
4. Lederer, Francis L.: Diseases of the Ear, Nose and Throat, pp. 1049-1106, Sixth Edition, F. A. Davis Co., 1952.

RECTAL INJURY

DRS. A. HATHCOCK AND J. D. MASHBURN

Presented by A. H. Hathcock

CASE REPORT

Hospital No. 71,765, 72,199 and 72,334

Patient: Age 15—Male. R. B.

This 15-year-old white male was brought to the Fayetteville City Hospital about 12:40 p. m. on 28th of January 1954, as an acute emergency. While working with his father he had accidentally fallen backwards into a circle saw. He was brought into the hospital in moderate shock—the pulse was about 90 per minute, and the blood pressure 80/60. There was considerable blood on the clothing and in the wounds, but no severe bleeding.

Physical examination revealed a slender, adequately nourished 15-year-old white male. There were no abnormal physical findings with the exception of moderate shock and the wounds sustained. There was a severe, deep laceration through the right buttock through the right sacroiliac joint and into the pelvic cavity and down on the posteromedial surface of the right thigh. The sciatic nerve was not injured. The rectum, from the sigmoid flexure down to approximately 3 in. from the anal sphincter, had been completely torn out. The right vas deferens was severed. The pelvic cavity was laid wide open as patient lay prone on the table. Wounds were cleansed with septisol and thoroughly irrigated wtih saline. Particles of stool were washed from the pelvic cavity. This injury destroyed the right middle hemorrhoidal vessels and the superior hemorrhoidal vessels. Why this patient did not bleed to death is problematical.

After thoroughly cleansing the posterior wound a sterile pack was placed in the wound, patient was turned on his back and given a general anesthesia. The abdomen was opened through a right paramedian incision. Exploration of the pelvis revealed that the sigmoid had been transected at the sigmoid flexure. Only fragments of the sigmoid and rectum were hanging in the pelvis. A large stool was lying at the end of the sectioned sigmoid at the pelvic brim. Stool was cleared out and a pelvic toilet was done as carefully as possible. The proximal severed end of the sigmoid colon was freed upward, severing the mesocolon

Fig. 1

Presented: Staff City Hospital, Fayetteville, Ark., Nov. 12, 1954.

Fig. 2

at considerable distance from the colon to preserve the blood supply. Enough of the large bowel was liberated so that it could be brought down well into the pelvis. When this was done, suture was placed in the end of the sigmoid and sutured to the pack already placed in the wound below. The pelvic diaphragm was closed. All bleeding points were controlled. A transverse colostomy of Mikulicz type was made by extending the abdominal incision up to the right of the umbilicus and placing the colostomy at the upper end of the wound after closing the abdominal wound. Patient was turned on his side, and the pack was drawn out, pulling the end of the sigmoid down to the skin edge. The end of the sigmoid was then sutured to the skin with interrupted sutures to maintain the length of the intestinal segment for anastomosis. The length of the operative procedure was four hours. Patient received 1500 cc. of whole blood during the surgery and immediately after the surgery. He received tetanus and gas gangrene antitoxin. Large doses of Dicrysticin were administered. Wangensteen suction was started shortly after surgery.

Patient ran a septic temperature, not above 102, for a period of two weeks. After that time his temperature remained normal, and pulse was essentially normal. Irrigation tubes were placed through the anal opening up into the pelvic cavity and through the wound posteriorly, for irrigation purposes. A tube was also placed in the descending portion of the large bowel from the transverse colostomy. All three irrigation tubes were used to wash out the pelvis and the lower segment of bowel.

Eight days after original surgery patient was readmitted to the operating room, and under general anesthesia the free end of the sigmoid, which had been attached to the skin, was anastomosed to the small portion of rectum which remained. About three inches of rectum remained attached to the anus. Anastomosis was performed posteriorly through the original incision. Interrupted cog sutures were used throughout. The post-operative course was uneventful with the exception that there was a large amount of purulent drainage from the perineal and posterior sacral wound. Daily irrigations through the colon and posterior sacral wound were carried out. After about ten days digital dilations of the rectosigmoid anastomosis were done every day or so. There was a small amount of leakage for the first two or three weeks at the anastomosis. The transverse colostomy functioned well.

Two weeks following the rectosigmoid anastomosis patient developed a small bowel obstruction, and it was necessary to reopen the abdomen and free some adhesions between the small bowel and the primary operative site at the pelvic diaphragm to release an intestinal obstruction of the small bowel. Patient ran a moderate septic course following this surgery. The highest temperature was 101 by mouth. Improvement was gradual, but definite. Patient remained in the hospital two months from the original date of admission, at which time he was discharged to his home for further convalescence. He returned to physician's office for dilation of the rectosigmoid anastomosis. Mother continued irrigations of the colostomy and anus. At the time of discharge from the hospital the major portion of the drainage from the pelvic wound had ceased. Date of discharge from original hospitalization was March 26, 1954.

Patient was readmitted to the Fayetteville City Hospital on April 16, 1954, for breaking down of the colostomy spur. Clamps were placed on the colostomy spur, and a gradual breaking down of the spur was accomplished. He was discharged from the hospital on 23 April, seven days later.

On May 10, 1954, patient was readmitted to the City Hospital for closure of the colostomy wound. The rectal anastomosis was functioning perfectly, as shown by enemas and irrigations from the transverse colostomy. X-rays in physician's office revealed a good functioning anastomosis. He received antibiotics about four or five days preliminary to the closing of the colostomy. The colostomy was closed under general anesthesia on May 12, 1954. Patient made an uneventful recovery, and a normal B.M. on the fourth post-operative day. Mineral oil and milk

of magnesia were used to soften the stools. Patient had daily spontaneous B.M.'s after the fourth post-operative day. Wound was dressed on the seventh post-operative day; sutures removed; and wound was clean and healing nicely. There was no infection. Patient was discharged from the hospital. A small granulating area on the right buttock, from the original wound, remained open.

This case is of interest from the standpoint of severity of injury and a satisfactory result. Prior to modern day antibiotics a fatality would have been almost inevitable.

This young man has normal bowel movements without tenesmus or urgency. He walks without limp, can do deep knee bends and stooping exercises with ease and without discomfort. His wounds are healed.

COMING EVENTS

ARKANSAS MEDICAL SOCIETY

Hot Springs, May 30-June 1, 1955

NEW ORLEANS GRADUATE MEDICAL ASSEMBLY

March 7-10, 1955

UNIVERSITY OF TEXAS POST-GRADUATE SCHOOL OF MEDICINE

Temple, Texas, March 7-9, 1955

AMERICAN ACADEMY OF GENERAL PRACTICE

Los Angeles, March 28-31, 1955

THE AMERICAN CONGRESS OF PHYSICAL MEDICINE AND REHABILITATION.

The 33rd annual scientific and clinical session of the American Congress of Physical Medicine and Rehabilitation will be held August 28-September 2, 1955, inclusive, at the Hotel Statler, Detroit.

Scientific and clinical sessions will be given August 29, 30, 31, September 1 and 2. All sessions will be open to members of the medical profession in good standing with the American Medical Association.

Full information may be obtained by writing to the executive secretary, Dorothea C. Augustin, American Congress of Physical Medicine and Rehabilitation, 30 North Michigan Avenue, Chicago 2, Illinois.

The Ninth Annual M. D. Anderson Symposium on Fundamental Cancer Research will be held March 10, 11, and 12, 1955, at the University of Texas M. D. Anderson Hospital and Tumor Institute in the Texas Medical Center, Houston.

Names making news at this Symposium are Eleanor MacDonald, University of Texas, John Fertig, Columbia University, George Gomore, University of Chicago, and A. Clark Griffin, M. D. Anderson Hospital, Houston, Texas.

International College of Surgeons Southwestern Divisional Region meeting, Houston, Texas, February 28-March 1st, 1955, at the Shamrock Hotel.

Our Neighbor Invites Us to an INSTITUTE ON ORAL CANCER

Oral Cancer—a malady with increasing frequency by dentists and physicians, and one which can be treated with much increased chances of success if caught in the early stages—is the subject to be taken up by dentists and physicians in a series of three Mississippi Institutes this March. Emphasis will be the part both dentists and physicians can take in oral cancer's early detection and treatment.

Sponsored by the Mississippi Dental Association in cooperation with the Mississippi Division, American Cancer Society, the Mississippi State Medical Association, the Mississippi State Board of Health, the Mississippi State Board of Dental Examiners, the Mississippi State Board of Medical Examiners, and the University of Mississippi, the Institutes will be duplicated at three locations: The University of Mississippi on March 23, Jackson, Miss., on March 24, and Gulfport, Miss., on March 25.

A distinguished faculty, each member of which is both a dentist and a physician, will act as instructional team at each of the one-day Institutes.

Certificates will be presented to those attending by the University of Mississippi.

Bulletins and other information is available by writing the University of Mississippi, (Department of Conferences and Institutes), Oxford.

The Medical School of Indiana University received $29,000 **more** funds from physicians and Alumni than **any other medical school** in 1953. The reason was that some group in Indiana got down to action. Perhaps it was the Alumni Association.

★ Editorial ★

GUEST EDITORIAL

Political predictions, like any other predictions including some of the weather forecasts, are notoriously unreliable. Political landslides and hurricanes have been known to upset the prognostications of some very astute observers. In this column two months ago, we said that some Congressmen—an inclusive term meaning senators and representatives—were sitting on the fence and that "those Congressmen who are coming up for re-election and who have been coasting on the President's popularity may have considerable difficulty retaining their grasp on his coat tails. Some of them may be retired to the hinterland."

This has come to pass. Not that we had any particular foresight into a forthcoming election but simply that it became more and more obvious as the summer passed that a number of incidents in and out of the 83rd Congress, some of the shenanigans of bizarre politicians and the millionaire cabinet's attitude toward the average citizen were looked upon with some disfavor by a large number of voters.

To be more specific, a large segment of the electorate was opposed to giving away the off shore oil rights in the Gulf of Mexico, trying to transfer Bonneville Dam values to private interests, hampering and curtailing TVA, promulgating the Dixon-Yates contract with its subsequent embroglio and its implication of injury to the TVA, passing a tax reduction bill that was not equitable, the Eisenhower-Hobby scheme of re-insurance for medical care, denying the existence of obviously increasing unemployment, Mr. Wilson's disrespect to labor by his dog gone yarn, Mr. Dulles' ineffectiveness, increased interest rates on banker's loans to the nation, letting McCarthy run amuck without restraint much too long, and holding up the report of the committee looking into his activities until after election.

These are regrettable items on the debit side of the ledger and among the causes of the failure of the President's party to retain control of Congress.

To help balance the books it should be pointed out that the 83rd Congress has to its credit the cessation of the Korean War, the St. Lawrence Seaway bill, increased social security benefits (?), rejection of the Bricker Amendment (A) and rejection of statehood for Hawaii and Alaska which is proper because they are not contiguous with the U. S. This is good legislation, but apparently not sufficient.

Eisenhower was elected on his personal popularity and his own program. Every effort should have been made to align the party with the winner's policies, instead of trying to change the winner's ideas into alignment with the party.

When the new Congress convenes in January undoubtedly it will be about as responsive to the President as the previous Congress was. On matters of foreign policy, Mr. Eisenhower has needed Democratic votes, and he will continue to receive them. On economic policies he may have to compromise a little, but not an excessive amount. In both houses committee chairmen will be Democratic but they will not be the fire eating ones, they will be Democrats tempered by age and sobered by long service. The wild men of either party will not be much in evidence next year. Mr. Eisenhower can get things done in his usual persuasive and compromising manner during the second half of his term almost as well as he could have done if he had retained his so-called majorities.

Editor's Note: This editorial is taken from the December '54 Bulletin of the Michigan Academy of General Practice. We have, in previous commitments, credited the now dead, but unlamented Joe Stalin, with both the beginning and the cessation of the Korean War, and differ in this respect from our guest editor, Charles Sellers, Detroit, Michigan. We further admit that we are not sure whether the off-shore oil contest mentioned above was a "give-away" or whether it was an attempted steal from the states. But the editorial is outstanding in these days of the 84th Congress, and is offered as a timely matter. The question marks are ours.

Davis W. Goldstein, Fort Smith, was honored December 10 with the "Golden Deeds" award of the Fort Smith Exchange Club. A long list of his public services was read. The award is made by the club "to a person it believes has given unselfishly of his time and substance to make the lives of his family, friends, and neighbors a little better and happier." The Journal salutes Dr. Goldstein for his well deserved recognition.

CORRESPONDENCE

Dear Editor:

This Spring, as you know, we will be involved in giving the Salk vaccine. We are trying to make preliminary plans in the Polio advisory

committee, to meet the situation with a suggested plan of organization working jointly with the State Education Department and the State Health Department. I am sure we will be under a great amount of pressure from all directions.

The National Foundation for Infantile Paralysis has agreed to provide technical information in regards to giving the vaccine and also information for public information, to avoid some of the errors of last year's trial vaccine. We the Polio Committee are requesting your aid in helping provide the necessary information through State Journal to the physicians in the State. The vaccine will be made available for the asking to any first or second grade children in the state. We are now working on the plans for giving the vaccine on a statewide basis. This will be a tremendous job and will require a great deal of volunteer work on the part of all physicians in the state.

We will do our best to give you further information, as soon as it is available.

Sincerely,
Eugene H. Crawley, M.D.

Dr. W. R. Brooksher, President
Arkansas Medical Society
Fort Smith, Arkansas
Dear Dr. Brooksher:

The members of our association wish to express their deep appreciation for the wonderful help given for the organizational meeting of the Arkansas State Medical Assistants Society. We shall be ever grateful for the support, cooperation and contribution of the Arkansas Medical Society to this highly successful meeting, which exceeded all expectations.

Sincerely yours,
(Mrs.) Elizabeth D. Marsh,
Corresponding Secretary.

The ink was scarcely dry on our commendation of Mr. Raymond Moley elsewhere in this Journal when we read with interest his analysis of the Senators of the United States now in Congress, published in Newsweek recently.

It was no surprise to see Senator John L. McLellan listed as a middle-of-the-road statesman who has acquired considerable esteem and power in Washington by the simple method of sound judgment and hard work.

It was a surprise, however, to see Mr. Moley list Arkansas' other Senator, J. W. Fulbright, as a "left-winger." We simply don't believe this. To quote more accurately, Mr. Moley listed Mr. Fulbright as a "Left-wing Democrat." If Moley had been more accurate, he would have known that a "left-winger" is NOT a Democrat. Left-wingers are the destroyers of the American System of government. Some of them have the intellectual dishonesty to claim to be Democrats or Republicans for the sole purpose of being elected. There is no other connection. Senator Fulbright is a Democrat and no "left-winger." We are confident that his voting record will support our opinion and not Mr. Moley's, both in the past and in the new Congress.

There are dangerous "left-wingers" in the Senate. But they don't come from Arkansas.

Obituary

GIBBS BISCOE, 74, Dumas, died in a Dumas hospital, December 26, after a long illness which forced his retirement from active practice in 1947. He was a member of the Arkansas Medical Society and formerly took an active part in it, and his county medical society. He was a native of Mississippi, and came to Arkadelphia where he attended Ouachita College.

His medical degree was obtained from the Philadelphia College of Medicine. He practiced his profession in Dumas for 44 years.

Survivors include a daughter, a brother, and two grandchildren.

Funeral services were conducted in the 1st Methodist Church. Burial was in Bellwood Cemetery in Pine Bluff.

Word has been received of the death of a former member of the Arkansas Medical Society, Solomon F. Hoge, 68, in the Veterans Hospital at Wadsworth, Kansas, on December 26, after a long illness.

He occupied the Chair of Pathology in the University of Arkansas Medical School for several years, and left Little Rock in 1925.

He served as director of laboratories at the Veterans Hospital at Fayetteville, from 1946 to 1951, and after his retirement from the VA was director at the Golden Clinic, Elkins, W. Va.

A graduate of the University of Pennsylvania, he was a fellow of the College of American Pathologists and a diplomat of the American Board of Pathology.

His widow, a son and a daughter, all of Leavenworth, survive.

Funeral services and burial were held at Little Rock.

Arkansas TRAVELING

And Clipping Bits Here and There

It isn't often that we have quoted Mr. Raymond Moley in the past, but time seems to have helped him. We now quote him from **Newsweek:**

"A conservative is never spectacular or glamorous. He is not news. He does not excite—or thrill. He just builds and moderates, and saves, and remembers. But for him, we would dissolve into our primordial elements. But the conservatives are the normal state of affairs. **We never needed them more than at this moment of instability, fear, and mutual distrust."** (Heavy type, ours.)

EASE THE BURDEN OF YOUR PATIENTS

Practicing physicians should bear in mind that the issue of government-controlled medicine is not dead. We have a period at hand in which we can build for the future. Now is the time to take action so that we can promote good-will between the medical profession and the public. It is most important that in attempting to solve our problems we try also to find a solution to the patients' problems. Whatever we can do to ease the burden of the patients' financial load will win for us friends who can be of inestimable value in a battle against socialized medicine, if such should ever occur again.—The Pennsylvania Medical Journal, Dec., 1954.

AND FROM THE A.M.A.'s NEWSLETTER:

Special Delivery. The "Dad Dearborn" letter on the editorial page of the Chicago News, a daily feature with a humorous slant, was directed recently to A.M.A. President Walter B. Martin. It said: "Dear Walter: The figures show 1954 to be the healthiest year in the nation's history. In view of all the goings-on of a sort to make people sick, that's a record to be proud of."

Dr. Judd to Speak at Rural Health Conference. A physician-statesman will be the headline speaker at the A.M.A.'s 10th national Rural Health Conference February 24-26 at the Schroeder hotel, Milwaukee, Wis. The Honorable Walter H. Judd, M.D., Congressional Representative from Minnesota, will speak on "Rural Health and World Peace" at the Friday evening banquet. Also featured on the banquet program will be the Medichoir—composed of 45 medical students from the University of Wisconsin.

Other highlights of the conference: Panel discussions on farm and home safety; family responsibility for health; use of our present health and medical care resources.

Community Health Week Set for March. It's likely that the Junior Chamber of Commerce chapters in 1955 will sponsor Community Health Week in cooperation with the National Health Council. Dates for the nationwide observance are March 21 through March 27.

The week's program potentially can enlist 180,000 young business men in 2,800 communities in an intensive effort to "Know Your Community Health Resources" and, for that reason, medical societies are being urged to lend their support whenever asked.

Junior Chamber of Commerce chapters already have been asked to name Community Health Week chairmen and to get in touch with local health leaders. National Health Council members also are alerting their local and state affiliates to the Community Health Week plans and urging cooperation and guidance.

Since observance of Community Health Week involves the medical profession directly, it is imperative that we be prepared to advise and guide the Junior Chamber.

Politics and Medical Care. Someone mailed Dr. F. J. L. Blasingame, A.M.A. Trustee from Texas, the following clipping entitled "Private Security," from the Dallas Morning News:

"Ninety-five of every 100 workers are now covered by some kind of private—not government—benefit program. This is not the brag of private business. It is a government figure.

"Nine of ten have life insurance. Eight of ten have hospital insurance, and more than half of those have surgical policies. Six of ten are covered for sickness and accident. Five of ten have medical care. Six of ten have their own company pension coverage.

"Yet, there is growing pressure in Washington for the Federal Government to get into the medical business. It makes just as much sense as the government going into the automobile business so that those who don't have a car can have one—at taxpayers' expense. That pressure is for political 'care,' not medical care."

TUBERCULOSIS ABSTRACTS

A Review for Physicians

ISSUED MONTHLY BY THE NATIONAL TUBERCULOSIS ASSOCIATION

INCIDENCE OF TUBERCULOSIS AMONG HOMELESS MEN

By HERBERT W. JONES, JR., M.D., JEAN ROBERTS AND JOHN BRANTNER

Journal of the American Medical Association, July 31, 1954

This study, an 11 months' intensive case-finding survey, is based on the client population of the Salvation Army Men's Social Service Center in Minneapolis. The center provides a rehabilitation program for homeless men. The majority of these men come on self-referral from "Skid Row," although, at any given time, about 10 per cent of the clients have been referred for rehabilitation as physically handicapped, 10 per cent as parolees and probationers, and about 10 per cent as provisional dischargees from the state hospital system. About 70 per cent of the client population regards the abusive use of alcohol as its major problem.

For five years preceding the start of this study, the Center depended on the periodic visits of the Christmas Seal Mobile X-ray Unit of the Hennepin County Tuberculosis Association to check the health status in regard to tuberculosis. During this period, no noticeable difference in incidence between the population here and the general population in Minneapolis was noted. However, it was felt that, since a third of the client population stayed less than one month, a routine weekly program of taking chest roentgenograms would give more complete coverage of the population. This was instituted in October, 1952, through the cooperation of the Minneapolis Public Health Division and the Hennepin County Tuberculosis Association. The results that follow are based on a survey of 405 consecutive chest roentgenograms taken routinely from October, 1952 through August, 1953. During that period all men who stayed at the Center at least one week were examined by means of a chest roentgenogram. Of the 405 who were screened, five per cent were under 30 years of age; 17 per cent between 31 and 40 years old; 33 per cent between 41 and 50; 35 per cent between 51 and 60, and 10 per cent 61 or older. The transient nature of the group is apparent from the fact that 30 per cent were residents of the city of Minneapolis; 20 per cent were residents of the state of Minnesota, and 50 per cent were considered "federal transients," since they had no established residence in any state. The results of this survey are shown in the table.

Results of Surveys Among Selected Population Groups in Minneapolis

Groups	Number Screened	New Cases of Tuberculosis Found		New Cases per Thousand Persons Screened	
		Total	Active	Total	Active
Men's Social Service Center, October, 1952, to August, 1953	405	14	9	34.6	22.2
Hennepin County TB Association Mobile Unit, 1952	53,995	149	20	2.8	0.4
Minneapolis industries	23,081	53	3	2.3	0.1
Institutions	6,655	52	6	7.8	0.9
School students and personnel	14,449	7	3	0.5	0.2
Other general groups	9,810	37	8	3.7	0.8
Minneapolis workhouse survey, 1952	2,238	18	4	8.0	1.8

In considering these results one should note that, in the portion of the population that was surveyed, the rate of active new cases per 1,000 is 22.2, compared with the similar rate for the Hennepin County Tuberculosis Association Mobile Unit survey of the general population of 0.4 per 1,000 in 1952. The rate in the population group surveyed is 55½ times as great as the general rate in Minneapolis for that year. The difference in the incidence of tuberculosis between these two groups is highly significant.

It is recognized that the rate of new cases found is related to the intensity of the search for them. However, this factor probably does not account for most of the difference in rates, especially since the rate of new active cases in the sample

of homeless men is 13.4 times as great as the rate found in the Minneapolis Men's Workhouse population, the most nearly comparable survey both as to population composition and to intensity of search. This high rate of incidence of tuberculosis occurs in a transient, very mobile population group. It occurs in a population group that in general lives under conditions that are likely to foster infection of others in the same group. The men in this group sleep generally in dormitories, whether in the cheap hotels or in the various rehabilitation centers throughout the country. They are generally in fatigued physical condition, and their standards of cleanliness and personal hygiene tend, through economic necessity, to be low.

This rate occurs in a population group that is very likely to take temporary jobs as food handlers—cooks, cooks' helpers, dishwashers, etc.—situations in which the possibility of transmission of the disease to the general population is a factor. This rate occurs in a population group that is not limited to Minneapolis and that by its very nature can be presumed to exist in every large urban center in the United States. There is no reason to suppose that the rate of incidence found in Minneapolis is very much different from the rate that would be found by similar surveys in other cities. Indeed, it is very logical to assume that, in a survey that covered not only the younger groups such as those applying for admission to the rehabilitation centers but the entire "Skid Row" population, including the older, more permanent residents, the rate would be higher. This survey reveals an important aspect of the public health problem of tuberculosis. The homeless men quite probably constitute a primary source of reinfection for tuberculosis in the United States. Any public health program that has as its aim the eradiation of tuberculosis in our population should take particular account of this segment of the population. The study points to the need for intensified case-finding surveys of the populations of our "Skid Rows" and of our rehabilitation centers.

Personal and News Items

E. C. Moulton, Jr. and C. S. Lane, Jr. have moved their office from Merchants National Bank Building to 1214 North "B" Street in Fort Smith.

Three new members have joined the Cooper Clinic in Fort Smith within the last two months. George W. Allen, will do internal medicine and cardiology, Don E. King will join their surgical staff and Harry B. Eisberg is an orthopedist.

O. R. Holloway has closed his office in Morrilton, and joined the staff of the State Hospital in Little Rock.

Robert H. Ray, Earle, moved his offices to West Memphis early in December. He will be associated with Richard Cuonzo.

Stanley Applegate is the chief of staff of Springdale Memorial Hospital for the coming year.

St. Mary's Hospital, Dermott, will open a new, thoroughly up-to-date wing to the public about February 15th.

Wilma Sacks, Fayetteville, Public Health officer for Washington and Benton County, addressed the Washington County Medical Society on January 4, 1955. At the same meeting Mr. Honomichl, Sanatarian, made a talk on the surveys made by his department.

A. R. Brown, Searcy, has re-joined the Hawkins Clinic Hospital following a tour of duty with the Army in Europe.

James D. Huskins and Caldeen D. Gunter, both of Siloam Springs, are planning new medical Center offices to be opened late this year. Offices for two dentists are included.

A. Meryl Grasse, Calico Rock, opened new offices there on January 1st.

Earl D. McKelvey, Paragould, is the new President of Green-Clay County Medical Society. O. H. Clopton, Rector, is Vice-President, and J. M. Williams, Secretary-Treasurer. Alfred Maddox, Paragould, is delegate to the Arkansas Medical Society, and Don Purcell, Paragould, is alternate.

Wayne Stanfield was elected President of the Jackson County Medical Society at the December meeting in Newport. Haymond Harris, Newport, is Vice-President, and J. D. Ashley, Newport, is Secretary.

James W. Headstream of Little Rock was one of the speakers at a recent meeting of the Louisiana Urological Society. The other guest speakers were Norborne Powell of Houston, Texas, Keller Doss of Fort Worth, Texas, and Robert K. Womack of Shreveport, Louisiana.

Robert A. Calcote announces the reopening of his offices for the practice of ophthalmology in Little Rock.

Sandoz Pharmaceuticals is the newest of the drug houses to make available to County Medical Societies certain films of interest to physicians only. Their address is Hanover, New Jersey.

J. Harry Hayes, Little Rock, left in October for Japan, where he attended the inauguration of the Japan Chapter of the International College of Surgeons at Osaka. His group next visited Hong Kong and inaugurated a Chapter there. Chapters were visited in Bangkok, Thia and Bombay. The return trip included programs in Istanbul and several European cities.

From Pakistan they went to Istanbul, Turkey, and gave a scientific program to the Turkish Section. And from there a scientific session was held in Telaviv and then in Athens, Greece. The return trip was via Rome, Madrid, and Lisbon, where they visited hospitals, clinics, etc., and by Paris and London.

R. B. Robins, Camden, addressed the Pine Bluff Rotary Club on January 4.

Ben D. Means is new Chief of Staff at Arkansas Baptist Hospital in Little Rock. Elvin Shuffield is Vice-Chief and Paul Hoover, Secretary.

Contributors to the American Medical Education Foundation from the State of Arkansas during December, 1954:

T. M. Durham, Jr., Hot Springs.
Fount Richardson, Fayetteville.
Ben N. Saltzman, Mountain Home.
Morton C. Wilson, Fort Smith.

Karr Shannon has moved from Melbourne to Newport where he will be associated with Thomas E. Williams.

Proceedings of Societies

ARKANSAS RADIOLOGICAL SOCIETY

The Arkansas Radiological Society met in call meeting in lieu of the regular quarterly meeting of January, 1955, on Friday, December 3, 1954, at 6:00 p. m. in Little Rock. A business meeting followed. Dr. Burton introduced Dr. Robinson of Harrison, Dr. Baker of El Dorado, and Dr. Barnhard of Little Rock. Dr. Robinson's application for membership was read and approved. Dr. Burton reported on the interim meeting of the House of Delegates of the Arkansas State Medical Society recently held in Little Rock.

Following the business session our guest speaker, Dr. Frederick P. Ellinger, Chief Radiation Biologist of the United States Naval Research section, Bethesda, Maryland, was introduced. He presented a very thorough and most interesting discussion on the biological effect of ionizing radiations. Considerable discussion followed.

Following this presentation an interesting film reading session was moderated by I. Meschan.

Members in attendance were: Baker, Meschan, Burton, Anderson, Law, Rhinehart, Robinson, Norton, Calhoun, and Scruggs. Associate members in attendance were: Crow, Sims, Egner, Morrison, Bice, Brogden, and Blake. Guests present were: Landsman, Barnhard, and Ellinger.

Joe Norton, Secretary.

The Craighead-Poinsett County Medical Society met January 5th at Jonesboro with 48 members present. Speakers and their topics were: Henry Rudner, Jr., Memphis, "Obesity"; Henry Turner, Memphis, "The Latest Phases in Obstetrics."

National Hospital Week in 1955 will be May 8-14. During this week the attention of the American public is focused on our hospitals, in which one out of every eight of us receives care

each year. The theme of National Hospital Week in 1955 will be "Your Hospital . . . A Tradition of Service."

National Hospital Week is sponsored annually by the American Hospital Association. Celebration of a National Hospital Day began in 1921 and is traditionally built around the May 12 birthday of Florence Nightingale, the famous nurse whose pioneer service led to the improvement of hospital care.

A. J. Forestiere of Harrisburg was elected president of the Craighead-Poinsett Medical Society at the annual election of officers held at a meeting in Jonesboro. Dr. Forestiere is also commander of C. C. Hill Post No. 14, American Legion, treasurer of the Harrisburg Jaycees, and a member of the Harrisburg Rotary Club.

The Crawford County Medical Society elected M. C. Edds, Mulberry, as its president for 1955. O. J. Kirksey, Mulberry, was elected vice-president, and A. E. Thorne, Van Buren, Secretary.

NEWS OF S.M.A.

Arkansas physicians have a great stock in the Southern Medical Association. No less than a dozen of our members participated in the November meeting in St. Louis in 1954. The programs are tuned to the needs of the profession in our area. The speakers are those who face problems common to us all.

With our connections so close, members of the Arkansas Medical Society will rejoice at recent honors conferred on the President of S.M.A., Robert L. Sanders, Memphis, and others of the organization. This group of distinguished physicians included Tom D. Spies, Birmingham, Louis H. Bauer, Secretary-General, World Medical Association, the Professional Relations Advisor to S.M.A., Mr. C. P. Loranz, Birmingham, and Elmer Hess, President-Elect of the American Medical Association.

These distinguished medical workers were honored in Havana, Cuba, on December 3 by being presented an award, "The Order of Carlos J. Finlay" from the Academy of Science, Havana. The presentations were made by the President of the Republic of Cuba.

These same honorees were recognized on the same date by the Colegio Medico National de Cuba when they were given honorary memberships in the College. This latter list also included Elmer Hess, President-Elect of the American Medical Association, who gave an address before the Assembly.

WOMAN'S AUXILIARY

President of the Woman's Auxiliary to the Arkansas Medical Society, Mrs. Hoyt Choate, visited Jonesboro and Batesville during the month of December. She requests all Auxiliaries to watch the Journal and newspapers for the statewide Doctor's Day Observance.

Mrs. Mason Lawson, President-Elect of the Woman's Auxiliary to the American Medical Association, will speak at the Rural Health Conference in Milwaukee on the 27th of February.

The Garland County Medical Auxiliary was entertained with a program on yuletide customs of other lands at the group's Christmas meeting in the home of Mrs. Charles T. Young. Mrs. Young began the program with a brief talk on Christmas activity peculiar to other lands. Mrs. P. A. Bergman related interesting German customs also showing colored slides; Mrs. Merle Powell who lived in Japan for a time told of New Years' customs, also accompanied with colored slides. Miss Dora Jane Ledgerwood told of the Christmas card's origin, and Mrs. Pierre Dossman read the poem, "True Christmas." Children, Kay and Tink Young with Phyllis and Vicki Bergman accompanied by Miss Ledgerwood sang Christmas carols in French, German, and Japanese. A brief business session, opened with prayer by Mrs. Homer K. Wright, was conducted by Mrs. Cecil Parkerson, president. It is an annual project of the Auxiliary to bring gifts for children selected by the county welfare agency. Wives of the Army and Navy Hospital doctors were hostesses for this Christmas meeting.

MRS. O. A. SMITH,
Publicity Chairman of Garland County Medical Auxiliary.

Woman's Auxiliary to the Pulaski County Medical Society have held monthly luncheon meetings at the Y.W.C.A. in Little Rock with these interesting programs: the State President, Mrs. Hoyt Choate, talked in October on her trip to the A.M.A. and her plans for the year; in November the Reverend Richard Hardie of the Westover Hills Church spoke on "The Christian Approach to Sex"; a Christmas program was planned for December with Mrs. Eugene Stewart giving the Christmas Story and the Fair Park School Choral Group giving the musical selections. Mrs. Eugene Crawley, Nurse Recruitment Chairman, held an open house for the Future Nurses Club of Central High School and has been working

on plans to organize a Future Nurses Club in North Little Rock. The Public Relations Chairman, Mrs. Dale Alford, organized a group of doctor's wives to collect funds from the doctors for the Community Chest and went over the top on their goal. Mrs. Edwin Gray is serving as President of Pulaski County Medical Auxiliary this year.

MRS. JAMES NEWBILL.

Mrs. Erner Jones, State Mental Health Chairman, along with the Arkansas Medical Society, Pulaski County Medical Auxiliary, and the Health Department, is sponsoring a preview of Mental Health Films on January 14th. This will be a continuous showing, in order that all groups over the state as well as within the city might see what film they would prefer to show in their community or their group. Mental Health chairmen of all auxiliaries have been asked to come to Little Rock to see these films.

The Woman's Auxiliary of Benton County Medical Society has as their project for the year, Nurse Recruitment. At present they are working with the Siloam Springs nurses on the recruitment program; trying to visit the schools and we are also using material from the University of Arkansas School of Nurses to promote interest for the girls to stay in Arkansas.

They had a meeting with our State President. Also attended the district meeting in Fayetteville in October. Installation of officers for the ensuing year was held at that time. Each doctor's office has a copy of Today's Health. Mrs. Lee Dean, President of the Benton County Medical Auxiliary gave a coffee for the members of the Auxiliary in early October. The Auxiliary members were asked to help with the cancer drive and to study the comic book clean-up.

Mrs. Dolly Siler
Benton County Medical Auxiliary.

The December luncheon and business meeting of the Woman's Auxiliary to the Jefferson County Medical Society, Pine Bluff, Arkansas, was held at the Hotel Pines. Mrs. W. T. Lowe dedicated her program to a discussion of the Golden Age. They discussed problems facing those over "80" and talked about ways they could help brighten the days of these older people. The date of February 12th was set for the Ninth Annual Davis Hospital Style Show Tea.

Mrs. Louis K. Hundley was installed in November as President of the Woman's Auxiliary to the Southern Medical Association. The installation took place at the annual meeting of the group in St. Louis. Mrs. Hundley is past president of the Woman's Auxiliary to the Arkansas Medical Society, past president of the Jefferson County Medical Auxiliary, past secretary-treasurer of the Southern Medical Auxiliary. For the past three years she has been Arkansas Chairman of Women's Volunteer Activities for the National Foundation for Infantile Paralysis. She is a member of the Pine Bluff Junior Auxiliary and the Sesame Club.

Mrs. E. L. Hutchison
Jefferson County Medical Auxiliary.

BOOK REVIEWS

When Minds Go Wrong: John Maurice Grimes, M.D. The Devin Adair Co., Inc., New York, 1954. Cloth. Pp. 246. Illustrated. $3.50.

Whenever one encounters a thought or series of studies running counter to the stream of general events it is usually from an author whose knowledge and general background on the subject is too limited to take at face value.

Not so the Dr. Grimes of this book. He has the authoritative background of complete acceptance of his work both before and during the studies which brought out the book. He is thoroughly acquainted with his subject. He holds up to question many of the practices in the mental hospitals of today. He supports his position with the knowledge that few mental patients are ever cured. He compares the present day treatment of shock by electricity, drug, or hot water with the older-day treatment of cold water shock, or with the whip. All these methods, he contends, are barbarious—even those done in 1954.

He questions the use of untrained personnel in such hospitals, and questions the professional honesty of many who work in these institutions.

If his solution for the problems he presents can be accomplished, then we can well adopt the suggestions he outlines in his book, and we can rework, revise, and renew, our outmoded system of mental patient care. One is not sure that his remedy will work, but the text is well worth reading, and his remedy worth trying.

Hugh Roy Cullen: A Biography: Ed Kilman and Theon Wright: Prentice Hall, New York. 1954. Pp. 376. Illustrated. $4.00.

A biography of a colorful living figure, and a king pin in the oil industry is presented, and proves both readable and entertaining. One's mind runs back to the Horatio Alger books of an earlier generation, and here is truly a modern counterpart.

The book leans a little to glamorizing, which is understandable. On the other hand, if one were to be fortunate enough to control the many millions that Mr. Cullen accumulated, one would be hard put to find a modern hero who would have distributed his largesse more generously, more wisely, or more soundly than Mr. Cullen. It is common knowledge that his support of medical projects, Baylor Medical School, and the cancer research work being done in Houston has been most liberal.

This "Story of American Opportunity" is the antithesis of some of the socializing theories of some of our long-haired friends. It reminds us that hard work and conservative thinking are still the two things that hold America together.

U. C. MEDICAL CENTER LIBRARY
MAR 24 1955
San Francisco, 22

MARCH 1955

THE JOURNAL OF THE ARKANSAS MEDICAL SOCIETY

VOL. LI No. 10

FORT SMITH, ARKANSAS

79th ANNUAL SESSION ARKANSAS MEDICAL SOCIETY
ARLINGTON HOTEL — HOT SPRINGS — MAY 30-31 - JUNE 1

Easy to give . . . and to take

ILOTYCIN DROPS

(Erythromycin, Lilly) Ethyl Carbonate

Unexcelled antibiotic spectrum—notably safe
Meets the exacting demands of
Physician—Mother—Baby

Lilly

Another reason to

consider ILOTYCIN FIRST

to combat resistant bacteria..

Chloromycetin®

The rising incidence of bacterial resistance to various antibiotics constitutes a serious therapeutic problem. Many infections, once readily controlled, are now proving difficult to combat. Administration of CHLOROMYCETIN (chloramphenicol, Parke-Davis) is often useful in these cases because this notable, broad-spectrum antibiotic is frequently effective where other antibiotics fail.

"...An advantage of CHLOROMYCETIN appears to be its relatively low tendency to induce sensitization in the host or resistance among potential pathogens under clinical conditions."*

CHLOROMYCETIN is a potent therapeutic agent and, because certain blood dyscrasias have been associated with its administration, it should not be used indiscriminately or for minor infections. Furthermore, as with certain other drugs, adequate blood studies should be made when the patient requires prolonged or intermittent therapy.

*Pratt, R., & Dufrenoy, J.: Texas Rep. Biol. & Med. *12*:145, 1954.

MEDICAMENTA VERA

PARKE, DAVIS & COMPANY • DETROIT 32, MICHIGAN

THE

Journal

OF THE

Arkansas Medical Society

Owned by
THE ARKANSAS MEDICAL SOCIETY
And Published Under Direction of the Council

FOUNT RICHARDSON, M.D., Editor
316 West Dickson Street Fayetteville, Arkansas

MR. PAUL C. SCHAEFER, Business Manager
215 Kelley Bldg. Fort Smith, Arkansas

The Advertising policy of this JOURNAL *is governed by the rules of the Council on Pharmacy and Chemistry of the American Medical Association.*

EXCLUSIVE PUBLICATION—Articles are accepted for publication on the conditions that they are contributed solely to this JOURNAL.

COPYRIGHT, 1955—By The JOURNAL *of the Arkansas Medical Society.*

NEWS—Our readers are requested to send in items of news, also marked copies of newspapers containing matter of interest to the membership.

OFFICERS OF THE ARKANSAS MEDICAL SOCIETY

W. R. BROOKSHER, President....Fort Smith
L. H. McDANIEL, President-Elect....Tyronza
T. P. FOLTZ, First Vice-President....Fort Smith
ELDON FAIRLEY, Second Vice-President....Wilson
R. H. WHITEHEAD, SR., Third Vice-President....DeWitt
J. J. MONFORT, Secretary....Batesville
DANIEL H. AUTRY, Treasurer....Little Rock
T. DUEL BROWN, Speaker, House of Delegates....Little Rock
C. C. LONG, Vice-Speaker....Ozark
MR. PAUL C. SCHAEFER, Executive Secretary
215 Kelley Bldg., Fort Smith

COUNCILORS

First District—JOE VERSER....Harrisburg
Second District—HUGH R. EDWARDS....Searcy
Third District—J. MAX ROY....Forrest City
Fourth District—L. K. HUNDLEY, Chairman....Pine Bluff
Fifth District—D. E. WHITE....El Dorado
Sixth District—HARRY E. MURRY....Texarkana
Seventh District—H. KING WADE, JR....Hot Springs
Eighth District—H. ELVIN SHUFFIELD....Little Rock
Ninth District—FOUNT RICHARDSON....Fayetteville
Tenth District—J. M. KOLB....Clarksville

VICE-COUNCILORS

First District—WAYNE WORKMAN....Blytheville
Second District—JOHN SNEED....Conway
Third District—J. P. WILLIAMS, JR....Brinkley
Fourth District—H. W. THOMAS....Dermott
Fifth District—GEORGE BURTON....El Dorado
Sixth District—CHARLES YARBOROUGH....Texarkana
Seventh District—RANDOLPH ELLIS....Malvern
Eighth District—ROBERT D. JONES....Little Rock
Ninth District—LEE A. DEAN....Rogers
Tenth District—LOUIE A. WHITTAKER....Fort Smith

Notice on Form 3578-P to be sent to the Arkansas Medical Society, 215 Kelley Building, Fort Smith, Arkansas. Published monthly under direction of the Council, Arkansas Medical Society, at Fort Smith, Arkansas. Vol. LI, No. 10. Subscription $3.00 a year. Single copies 50 cents. Entered as second-class matter, Sept. 23, 1947, at the post office at Fort Smith, Arkansas, under the Act of Congress of March, 1879. Acceptance for mailing at special rate of postage provided for in Section 1103, Act of October 3, 1917, authorized August 1, 1918.

• SPECIAL FEATURES

Committee on Cancer Control.... 221

The Surgical Aspects of Biliary Disease.... 222

Obstetric Trends in a Small Hospital.... 225

"Veterans' Medical Care—an Issue for Citizens".... 226

Annual Committee Reports.... 231

The Annual Essay Award.... 243

Program, 79th Annual Session, Arkansas Medical Society.... 244

• FEATURES

Tuberculosis Abstracts.... 255

Obituary.... 256

Personal and News Items.... 257

Proceedings of Societies.... 258

Women's Auxiliary.... 259

Auxiliary Board.... 259

Book Reviews.... 259

The JOURNAL
OF THE ARKANSAS MEDICAL SOCIETY
PUBLISHED MONTHLY UNDER DIRECTION OF THE COUNCIL

Vol. LI March, 1955 No. 10

Committee on Cancer Control

C. A. ARCHER, M.D., Chairman

ORAL CAVITY MALIGNANCY

The accessible location of cancer of the oral cavity should contribute to its early and prompt diagnosis. Visible and palpable, biopsy is a procedure without difficulty. The differential diagnosis must consider many entities, none of which carry the gravity as does that of malignancy. It must not be overlooked that cancer may be co-existent with any of the conditions which require differentiation, such as chronic infections, leukoplakia and the like. A lesion which fails to heal or to show definite recession within a period of not over three weeks is an indication for microscopical examination of the tissue. Treatment is by the use of surgery, roentgen-ray therapy and radium therapy, alone or by combination.

THE SURGICAL ASPECTS OF BILIARY DISEASE

W. EDWARD FRENCH, Memphis

In discussing the treatment of biliary disease, from a surgical viewpoint, the discussion is primarily concerned with diseases of the extra-hepatic biliary system. Although there are still many divergent views and considerable controversy concerning the management of various diseases of the extra-hepatic biliary system, there are certain indisputable facts that we must accept.

(1) Approximately 85% of the operations performed on the biliary system are for gall stones or the complications produced by gall stones.[1]

(2) The majority of patients with gall stones are likely to have one or more complications of gall stones, if they live a normal life expectancy.

(3) It is the complications of gall stones that kill the patient and not the stones themselves.

(4) The many complications — common duct stones, acute cholecystitis, perforation of the gall bladder with bile peritonitis, cholangitis, pancreatitis, hepatitis, carcinoma of the gall bladder, biliary fistulae, stricture of the ampulla of Vater, and infrequently intestinal obstruction caused by an impacted gall stone—which result from delay in the treatment of patients with gall stones, can be avoided by early recognition and surgical removal.[1]

From the above facts, we, therefore, have come to the conclusion that gall bladders containing stones should be removed unless other conditions make surgery too great a risk. This is particularly true in elderly people, since they tolerate the complications so poorly.[2]

Although approximately 10% of gall stones can be seen on a simple flat plate of the abdomen,[1] it was not until 1924, when Evarts Graham and Warren Cole published their discovery of a substance that was concentrated in the gall bladder and was radiopaque, did we have a means of studying diseases of the gall bladder.[3] This monumental work has done much to aid in the understanding and proper handling of gall bladder diseases.

Cholecystography has now become a most reliable means of studying the function of the gall bladder. Gall stones are usually reported as positive stones or negative stones. Negative stones are those which are not radiopaque. They are the true cholesterol stones. Positive stones are those which contain calcium. These stones can be seen frequently by the simple flat plate of the abdomen.

Quite frequently, the gall bladder will not visualize following the ingestion of the dye. There are several reasons for this. If hepatitis is present, the liver will not excrete the dye. Therefore, cholecystography is useless in the presence of jaundice. Anything that blocks the cystic ducts, such as, impacted stones or occlusion of the duct due to long standing disease, will cause failure to visualize the gall bladder.

It has been stated [1] that 50% of the patients with stones will have non-visualization of the gall bladder, whereas, 95% of those patients whose gall bladder fails to visualize, have stones. Therefore, one is justified in exploring a patient with symptoms typical of gall bladder disease and whose gall bladder cannot be visualized by cholecystography.

The technique of cholecystectomy is a fairly well standardized procedure with some individual modifications. It has been said that gall bladder surgery can be the easiest as well as the hardest of any abdominal surgery. The incision per se is rather unimportant. It is the exposure obtained by the incision that is of utmost importance. No place in surgery is exposure of more importance. The abdominal viscera are packed away and held away from the field by large Deaver retractors.

The dissection in the routine cholecystectomy is started mid-way of the gall bladder by incising the peritoneal covering near the liver margin. This is carried down over the common duct. No structure is cut or ligated until three structures are clearly identified. These are: the cystic duct and its junction with the common duct; the cystic artery; and the common duct. Mass ligation of the cystic artery and cystic duct is to be condemned. Most injuries of the common duct or hepatic artery occur during mass ligation or in an attempt to control hemorrhage.

The cystic artery should be ligated and divided first. This permits further dissection in a relatively dry field; it allows more traction to be permitted on the gall bladder and allows better visualization of the cystic duct; and it may prevent serious bleeding from tearing of the artery.

The cystic duct is then ligated and divided approximately 1 cm. from the common duct. However, it is much safer to leave too much cystic duct than to remove too much. The gall bladder

Presented at Craighead-Poinsett Medical Society, Jonesboro, Arkansas, 1954.

is then removed from below up, and its bed is closed with a running suture.

Occasionally, it will be necessary, particularly in acute cholecystitis, to remove the gall bladder from above downward. However, as mentioned above, no structure is ligated or divided until it is unquestionably identified.

The indications for exploration of the common bile duct are well known. However, I feel that more and more common ducts are being opened. The indications are: (1) palpable stone in the common duct, (2) dilated common duct, (3) thickened common duct wall, (4) small stones in the gall bladder with a large cystic duct, (5) history of jaundice with pain, (6) aspirated bile containing sediment, (7) pancreatitis.

If one has difficulty in being positive that the ampulla is open, then one should not hesitate to open the duodenum. If there is any narrowing or stricture of the opening of the ampulla present, then the sphincter should be incised.

Although most surgeons who explore the common duct drain it by means of a "T" tube, there are some who do not drain the common duct if no pathology is present. Granted that a common duct has been drained by means of a "T" tube, when should the tube be removed? This can be answered by stating that the length of time the tube should remain in place depends upon the amount of pathology present. If no pathology is found, the tube can be removed early. If cholangitis is present, the tube should remain in place until the cholangitis is healed. This can be determined by the clinical course, but it is usually one to three months.

Jaundice of Extra-Hepatic Origin

In discussing certain specific diseases which are treated surgically, the one probably causing the most concern is jaundice. The most common cause of jaundice, from an extra-hepatic origin, is the presence of stones within the common duct.[2] Other causes are tumors along the common duct, pancreatic lesions, and occasionally extrinsic pressure. The recent improvements in liver function tests are a great help in differential diagnosis of jaundice.[2] The alkaline phosphatase test is probably the most helpful test in determining obstructive type jaundice. The test is usually positive in obstructive jaundice.

It is common knowledge that painful jaundice usually means stone whereas, progressive painless jaundice means malignancy in the region of the ampulla. This does not always hold, but it is helpful in arriving at a diagnosis.

If the jaundice is of obstructive type, exploration of the common duct will be necessary in almost every case. If stones are found and removed, yet a probe will not pass easily into the duodenum, it becomes necessary to open the duodenum and inspect the ampullary region. It may be necessary to incise the sphincter of Oddi if a stricture of the sphincter or a narrowing of the junction of the common and pancreatic duct is present.[4]

If a tumor mass is found at the ampulla, there is a strong possibility that a malignancy is present. The best result obtained in radical resection of the pancreas and duodenum are in those cases of malignancies of the ampulla or lower end of the common duct.[5] The five-year survivals of those are equal to those in malignancies of the stomach.

Acute Cholecystitis

No other intra-abdominal disease is enjoying more controversy today as to the method of treatment than acute cholecystitis. The mere fact that acute cholecystitis is so frequent today is an indication of the "watchful waiting" type of treatment advised by so many physicians, in the early stages of the disease or in the so-called "silent gall stones." It is not appreciated that each attack increases the mortality by approximately two per cent.[6]

There is almost universal agreement even among the advocates of conservative therapy that those patients seen within 2 to 3 days of the onset of their disease, should have immediate surgery. However, more and more, we are certain, as soon as the diagnosis is established, the fluid balance restored, antibiotic therapy started, the appropriate surgery should be carried out without regard to subsidence of the disease or the number of days since its onset.[7] The appropriate surgery may be cholecystectomy with or without exploration of the common duct, or cholecystostomy.

It has been frequently stated, by the advocates of conservative therapy, that in the early stages of the disease, they rely on the "clinical impression" as to when surgery is indicated. This is a most important part in the treatment of any disease. However, in the treatment of acute cholecystitis, it is too inexact even in the best of hands. This is borne out by the frequent findings of empyema, gangrene, and perforation — often without significant variations in temperature, blood counts, or clinical findings.[6] In a recent report, from Harvard Medical School, which ap-

peared in Surg., Gyn. & Obst., after reviewing numerous cases from a pathological viewpoint, they were certain that there is essentially no correlation between the clinical picture and the pathological process found.[7]

Post-Cholecystectomy Syndrome

No discussion of biliary disease is complete without discussing a few of the causes of persistent pain following the removal of the gall bladder. Hardly ever is cholecystectomy indicated when no stones are present.

In the study of such patients one must eliminate the possibility that other diseases outside the biliary tract may be the cause of the symptoms.[2] These may be: duodenal or gastric ulcer, hiatus hernia, arthritis, pancreatitis, cirrhosis, or malignancies.

The lesions within the biliary system that may cause persistent symptoms are: (1) dilated stump of the cystic duct, (2) strictures of the common duct, (3) stone in the common duct, (4) chronic pancreatitis, and (5) strictures of the Ampulla of Vater.[2]

Strictures of Common Bile Duct

Strictures of the common bile duct can be divided into congenital and acquired. The congenital strictures are the atresias or stenoses seen in the newborn. No one has explained satisfactorily why a newborn with complete atresia of the common duct may not become jaundiced until several weeks after birth, yet an operative injury causing complete stricture will produce jaundice within 36 to 48 hours. Surgery is beneficial in those cases of atresia of the common duct when enough duct is found to permit anastomosis.[8] Many excellent results have been obtained where this is possible.

With almost no exception, injuries to the bile ducts occurring in the course of operations for gall stones produce one of the most unfortunate accidents that can occur in surgery.[9] It presents one of the most difficult problems of surgery. It usually occurs in a middle aged person who has a normal life expectancy had not the accident occurred.

The operative causes are numerous. More frequent than not the injuries of the duct occur in the hands of those untrained and unqualified to do surgery. The most common operative cause is probably mass ligation. Other causes are: (1) hemorrhage, (2) carelessness and haste, (3) angulation or tinting of the duct, (4) abscess as result of leakage of bile, and (5) chronic obliterative cholangitis.

Acquired causes, other than operative, may be traumatic, inflammatory, or neoplastic.

It is almost universally agreed by all who have had experiences in dealing with these unfortunate patients that a duct to duct anastomosis offers the best chance of recovery.[9, 10]. Cattell has devised a technic where this is frequently possible.[9, 10]. The pancreatic portion of the duct is mobilized and can be brought up to the hilus of the liver. However, in spite of this, all too many cases are seen whereby this cannot be done. It then becomes necessary to anastomose the upper portion of the biliary radicle to the duodenum or jejunum, or to attempt the so-called hepato-jejunostomy of Longmire.

Summary and Conclusions

(1) Silent gall stones should be removed to prevent complications.

(2) Cholecystography has become a reliable means of studying function of the gall bladder.

(3) In cholecystectomy, no structure should be ligated until the cystic duct, cystic artery, and common duct are clearly visualized.

(4) Most injuries to the common duct are preventable.

BIBLIOGRAPHY

1. Maingot, R., **The Management of Abdominal Operations.** MacMillan Co., 1953.
2. Cole, W. H., **Recent Trends in Gall Bladder Surgery.** J.A.M.A. 150:631, October, 1952.
3. Graham, E. A., and Cole, W. H., **Roentgenologic Examination of the Gall Bladder, A New Method Utilizing Intravenous Injection of Tetrabromophenalphthalein.** J.A.M.A. 82:613, 1924.
4. Cole, W. H., Ireneus, C., and Reynolds, J. T., **Strictures of the Common Duct.** Ann. of Surg. 133:684, May, 1951.
5. Cattell, R. B., and Pyrtek, L. J. **An Appraisal of Pancreatoduodenal Resections: A Follow-up Study of 61 Cases.** Ann. of Surg., 129:840, 1949.
6. Barksdale, J. W., and Johnston, J. H., **Acute Cholecystitis.** Ann. of Surg., 127:816, May, 1948.
7. Ross, F. P., Boggs, J. D., and Dunphy, J. E., **Studies in Acute Cholecystitis.** Surg., Gyn. & Obst., 91:271, Sept., 1950.
8. Gross, R. E., **The Surgery of Infancy and Childhood.** W. B. Saunders Co., 1953.
9. Lahey, F. H., and Pyrtek, L. J., **Experience with the Operative Management of 280 Strictures of the Bile Ducts.** Surg., Gyn. & Obst., 90:25, 1950.
10. Lahey, F. H., **The Technic of Repair of Strictures of the Bile Duct.** Surg. Clin. N. Amer. 31:719, June, 1951.

OBSTETRIC TRENDS IN A SMALL HOSPITAL

JOHN K. WALKER and CALVIN R. SIMMONS, Pine Bluff

Late in 1950, the staff of the Davis Hospital of Pine Bluff, Arkansas, was apprized of the fact that the cesarean section rate in our institution was nearly twice that of the national average. Following a general discussion, a committee of three obstetricians was elected whose duty it would be to pass on the advisability of cesarean section and tubal ligation on all candidates. A consultation by at least one member of this committee was required before the operating-room supervisor was allowed to set up for an operation.

Members of this committee are re-elected each year and consultations are without cost to the consulting physician and patient.

The Davis Hospital is a city-owned but self-sustained institution of approximately 120 beds. Staff privileges are conferred on any M.D. whose qualifications pass the admission committee of the Davis Hospital staff. There is an elected Chief of Obstetrics whose duty it is to see that the department is run in an ethical scientific manner. However, as anyone who has worked in a small hospital well knows, the control of any department is nominal. For this reason we felt the need for the above-mentioned committee.

The following is a review of the statistics for the past six years. The first three years (1948-1950) cover those years prior to the institution of the consultation rule; while the last three years (1951-1953) reflect the work done under this rule.

Chart No. 1

	1948	1949	1950	Av.	1951	1952	1953	Av.
Deliveries	958	1030	993	994	1011	1169	1199	1126
Cesarean Sections	86	93	66	85	54	55	34	48
Percentage Uncorrected	8.9%	9.0%	6.6%	8.5%	5.3%	4.7%	2.8%	4.3%

From this chart it is immediately apparent that the cesarean section rate has been reduced by half. We feel that this reduction has been almost entirely due to the institution of the consultation requirement. Our rate of 4.3% during the past three years is an uncorrected figure and probably does not reflect the true extent of the improvement. The fact has to be considered that many of these sections were repeats and the direct result of the high rate in the three years previous. A similar consultative set-up in a large New York hospital shows a cesarean section rate of 5.5%.[1]

Presented to the JOURNAL for Publication, 1954.

Statistics on primary sections are not available for the years 1948 through 1950, but we do have the figures for the past three years. Of the 143 cesarean sections of the latter three years, 59 were repeat sections. This leaves an average primary rate of only 2.5%, which is respectable under any standard.

For tubal ligations, we find that the consultation rule has reduced the ligation rate from an average of 81 a year to an average of 44 a year. Consultation is required only on post-partum tubal ligations. Ligations at the time of repeat cesarean sections are left to the discretion of the attending physician. We have not broken these ligations down into those concurrent with cesarean section against those done in the post-partum period, but the overall decrease has been very gratifying.

Chart No. 2

	1948	1949	1950	Av.	1951	1952	1953	Av.
Deliveries	958	1030	993	994	1011	1169	1199	1126
Tubal Ligations	61	106	76	81	50	52	30	44
Percentage	6.3%	10.6%	7.7%	8.2%	4.9%	4.4%	2.5%	3.9%

The consultation committee passes on the advisability of ligation on the medical indications alone. In a future compilation we plan to chart the indications used for ligation. With only three years of consultation rule to go by, we feel that the number of cases would be inconclusive.

Several correlated data have been compiled; some showing significant changes and some not.

For example, the maternal mortality rate has dropped from 0.30% per thousand live births during the years 1948-1950, to 0.08% during the last three years. These compare with a national average of 0.08% per thousand live births.[2] This drop, however, is not as significant as may appear, since none of the deaths during the first three years of this study were directly attributable to any cesarean section. It may be that the consultation rule has indirectly contributed to this lowered rate by promoting a closer cooperation among the members of the staff and therefore more consultations.

The rate of stillbirths has been unchanged throughout the six years of this study. Our rate of 2.4% compares favorably with the standard of 2.6% used by the Joint Commission on Accreditation of Hospitals in 1953.[3]

The percentage of neo-natal deaths has remained unchanged during the six years. A rate of 1.9% compared with the Standard of 2.0% used by the Joint Commission on Accreditation of Hospitals in 1953.[3]

The percentage of premature births has dropped from 6.1% during the three years prior to consultation rule to 4.6% since that time. It is hard to explain so great a drop on the basis of a reduced cesarean section rate alone, but the latter has been a factor.

Summary

1. A statistical study has been presented showing the improvement in the cesarean section and tubal ligation rates.
2. A comparison of the cesarean section and tubal ligation rates for three years prior to and three years following the institution of consultation requirements has been made.
3. Data related to reduction in these rates has been discussed.

Conclusions

1. A reduction in cesarean section rate from 8.5% to 4.3% has been effected.
2. A reduction in tubal ligations from 8.2% to 3.9% has been effected.
3. Maternal mortality, neo-natal deaths, prematures and stillbirth rates have not been materially changed.

REFERENCES

1. Shir, Gold, Daichman, Pomerance, and Soifer: A Proposal for Lowering Cesarean Section Incidence: A Voluntary and Educational Method for Staff Control. American Journal of Obstetrics and Gynecology, 66:319, 1953.
2. Dickinson: What We Get for What We Spend for Medical Care: J.A.M.A., 151:1028, 1953.
3. American College of Surgeons: Hospital Standardization Scoring Report, Part 2, No. 3.

"VETERANS' MEDICAL CARE—AN ISSUE FOR CITIZENS"

R. B. ROBINS, Camden

Mr. Chairman, Commander Collins, Fellow Members of the American Legion:

I am here today as a fellow veteran and a fellow Legionnaire. I also am here as an American physician engaged in the private practice of medicine.

But far more important than that—far more important than the fact that I am a veteran, a Legionnaire and a doctor—I am here today as **a fellow citizen** and a **fellow patriot**, dedicated as you are to the basic principles and ideals of American way of life.

The subject which I want to discuss—the issue of veterans' medical care—demands such an approach if it ever is to be solved reasonably and successfully. For that issue involves a national problem affecting the future health and welfare of all Americans—not only their physical and mental health, but also their social, economic and political welfare.

The problem will never be solved properly if it is viewed rigidly from a special interest standpoint by veterans, the American Legion, physicians, the American Medical Association or any other group or organization. It has to be decided by **all of the American people,** thinking and acting as **adult citizens**—with regard for the facts, with respect for differing opinions, and with concern for the best interests of the nation as a whole.

If we are to have an intelligent, adult decision on this vital national issue, there can be no place for undisciplined emotionalism, false patriotism, charges and countercharges, smear tactics or any other diversionary tactics which actually have nothing to do with the fundamental issue at hand.

Unfortunately, however, the past year and a half of controversy between the American Legion and the American Medical Association has beclouded the basic issue. Too frequently, facts, policies and motives have been distorted in an atmosphere of bitterness and denunciation. In all honesty, we of the Legion would have to admit that some of our **former** national and state officers have been especially intemperate and inaccurate in their statements on the issue of veterans' medical care—statements which have served only to malign the nation's physicians and confuse the general public.

Fortunately, there has been a refreshing change of climate during the very recent past. Our new

Delivered before the Mid-Winter Conference of the American Legion, Little Rock, January 21, 1955.

National Commander, Mr. Seaborn P. Collins addressing the House of Delegates of the American Medical Association less than two months ago at the AMA Clinical Meeting in Miami, Florida, gave a reasonable, unemotional presentation of the Legion's position on this issue. And I think he will agree with me when I say that he had an attentive, respectful and appreciative audience.

Commander Collins received enthusiastic applause when he told the AMA House of Delegates (and I quote) "Through the groups we represent, we both seek the betterment of America. In short, **We are citizens first, and doctors and veterans second."** (End of quote) — and again when he urged that the controversy over veterans' medical care be removed from what he called (quote) "the area of name-calling and propaganda." (End of quote.)

In that same Miami address, Commander Collins offered to appoint qualified American Legion representatives to serve on a liaison committee which would work with the AMA toward a better mutual understanding of the problem. He also expressed hope that the American Medical Association would see fit to take similar action.

Two days later the AMA Board of Trustees announced appointment of a three-man liaison committee including the Association's president-elect, a member of the Board of Trustees and the chairman of the AMA's Committee on Federal Medical Services—all of them physicians with a thorough knowledge of the background and facts on veterans' medical care.

Since then, Mr. Collins has named the members of the Legion liaison committee, and the two groups are scheduled to hold their first meeting around the middle of next month. In my personal opinion—as a physician, veteran and a citizen—I think all of us should rejoice at these recent developments. We now can **hope** that discussion of this issue will take place in an atmosphere of **reason** and **mutual respect,** rather than one resembling the smoky haze of a barroom brawl.

I myself would not venture to predict right now how much success these two liasion committees will be able to achieve. At this particular time, I doubt whether anyone—in the Legion, the AMA, the Veterans Administration or anywhere else—can foretell accurately just how much agreement or disagreement there will be. Regardless of the outcome—whether we agree, whether we compromise, or whether we disagree completely —let's resolve to do so **as adults, as gentlemen, as fellow Americans** . . . without villification or vituperation.

To put it in another way—as you've so frequently heard the referee say in prize fights—"I want de bode of youse to abide by de rules of de State Athletic Commission."

And to return to the English language—again as it was used by Commander Collins in his Miami address before the AMA—(quote) "If our two groups approach the subject of medical care for veterans in this sincere, honest and reasonable fashion, I believe that we can resolve our differences or at least achieve an understanding of each other's position which will permit us to continue to collaborate and cooperate in those fields where we do agree." (End of quote.)

In this spirit, then—the striving for a better mutual understanding—I want to outline briefly the American Medical Association's position on this issue. In particular, I want to clarify it if I can. For I am convinced—from conversations over the past year and a half with large numbers of Legion officers and rank-and-file members—that far too many of them do not have an accurate conception of the AMA policy. That impression was confirmed—to me, at least—by the tone and content of some of the national and state Legion resolutions which were passed last summer.

It has been charged, for example, that the AMA is engaged in "a continued, unwarranted attack on veterans as a class" or—in the words of one state resolution—"a vicious attack against the care of sick and disabled war veterans by the federal government."

Let me assure you, fellow Legionnaires, that nothing could be farther from either the spirit or the facts of AMA policy. That policy was formulated, after long years of study and discussion, to clarify the question of who deserves free VA hospital and medical care, and to enable the VA to concentrate on the best possible care for those who really need it.

The great majority of American physicians are themselves veterans, having served in uniform at one time or another from the Spanish-American War down to the present. During World War II alone, 40 per cent of the nation's doctors were in the armed forces. With sympathy for the problems of fellow veterans, and with a professional obligation toward all sick people, members of the medical profession would hardly be capable of indulging in a reckless attack against veterans as a class—**a class which includes most doctors themselves.**

Furthermore, the present high standards in VA hospitals are a direct result of the program carried out since World War II with the active, close cooperation of the medical profession and the nation's medical schools. **The very men who are supplying the best medical care ever received by American veterans can hardly be called "anti-veteran."** Actually, the American Legion and the American Medical Association have the common objective of working to maintain those high standards for the best benefit of the most deserving veterans.

It also has been charged that money—financial gain—the desire to pocket more private fees—are the real motives behind the AMA policy on veterans' medical care. Let's take a brief look at that one.

We in the American Legion claim that practically all of the non-service-connected cases in VA hospitals involve men who are "sick, broke and have no place to go." If we are correct in that, it does not follow logically that such patients would enrich the pockets of physicians in private practice. They still would have to be provided with free hospital and medical care, either from private or public sources.

Actually, the policy advocated by the AMA would most likely cause a loss of income for the medical profession as a whole. That policy would eliminate or sharply reduce the need for the services of large numbers of physicians who now are full-time VA staff members or part-time attending and consulting specialists. It is extremely unlikely that their loss of income would be off-set by any gain in revenue resulting from an increased number of veterans paying their own way. Let me assure you, on this particular point, that the medical profession is thinking **not** in terms of dollars, but in terms of **long-range** principles.

Another charge concerns the allegation that the AMA policy does not represent the rank-and-file opinion of American doctors—that it has been foisted on the nation's physicians and surgeons by a small minority of "top brass." In the first place, it was the doctors out in the grass roots, in many of the county medical societies, who made the original demands for the studies which led to adoption of the present AMA policy on veterans' medical care. Secondly, that policy was adopted after a great deal of free and open discussion by the AMA House of Delegates, a democratically organized body which expresses the viewpoints formulated first in the county societies and then in the state societies. Third, since the policy was established in June, 1953, it has been reaffirmed three times with little or no dissent. I can assure you—as a small town general practitioner and as a member of the AMA House of Delegates — that **a vast majority of physicians, both family doctors and specialists, agree with the AMA Policy.**

In this connection—and if I may be permitted to call a spade a spade—we in the American Legion are extremely Vulnerable whenever we accuse the AMA of not being representative of the medical profession.

As an active, loyal member of both organizations, let me point out this simple fact of life:—The Legion, with 3,000,000 members, represents less than 15 per cent of the nation's more than 20,000,000 veterans. The AMA, with a membership of over 150,000, represents 70 per cent of the nation's 220,000 physicians.

So much for some of the major misconceptions which have arisen over the AMA policy. I have touched upon them only because of a sincere desire to help clarify the issue—to help clear the air of suspicions and antagonisms—to help direct attention to the core of the subject. That subject is the AMA policy—what it is and what it isn't. Let me quote verbatim from the report adopted by the House of Delegates in June, 1953: (Quote.)

"Your committee recommends with respect to the provision of medical care and hospitalization benefits for veterans in Veterans Administration and other federal hospitals that new legislation be enacted limiting such care to the following two categories:

" '(a) Veterans with peacetime or wartime service whose disabilities or diseases are service—incurred or aggravated; and

" '(b) Within the limits of existing facilities to veterans with wartime service suffering from tuberculosis or psychiatric or neurological disorders of non-service-connected origin, who are unable to defray the expense of necessary hospitalization.'

"Your committee recommends that the provision of medical care and hospitalization in Veterans Administration hospitals for the remaining groups of veterans with non-service-connected disabilities be discontinued and that the responsibility for the care of such veterans revert to the individual and the community, where it rightfully belongs." (End of quote.)

In plain and simple language, what does that mean? It means, first of all, that **there is absolutely no difference of opinion—no argument—between the AMA and the Legion over service-**

connected cases. The AMA always has advocated—**and always will advocate**—the finest possible medical and hospital care for veterans whose illness or disability is a result of their military service. These are the men for whom the VA program was established and for whom the hospitals were built. On this point the AMA policy statement said: (And again I quote.)

"Your committee would like to stress the fact that these recommendations do **not** suggest any limitation or impairment of the hospitalization or medical care now available to veterans who have become physically handicapped as a result of military service. **We are in complete accord with that program."** (End of quote.)

There also is no difference of opinion — no argument—over war veterans with non-service-connected tuberculosis or neuropsychiatric disorders. The AMA believes that those veterans are entitled to government hospital and medical benefits if they are unable to pay for their own care. On this point the AMA policy statement included the following comment: (Again I quote.)

"The recommendations of the committee with respect to the treatment of veterans with tuberculosis and neuropsychiatric disorders of non-service-origin in federal hospitals is believed necessary at this time because of the inadequacy of local facilities designed to provide treatment for all such cases. It is the feeling of the committee, however, that the entire question of whether the care of these patients is a local or a federal responsibility must be reanalyzed by the Congress. The rapidly expanding veteran population and the need for facilities for the remainder of our citizens afflicted with these diseases suggests that community facilities must be developed under state or local administrations for the benefit of all. Preferential treatment for veterans with these non-service-connected disabilities cannot be continued indefinitely, in view of its detrimental affect on the health and the economy of the entire nation." (End of quote.)

At the moment, the only point upon which the AMA and the Legion disagree is the handling of **general medical and surgical conditions** which are **not** service-connected. These are the cases involving veterans who emerge from the service healthy and unhurt, but who later on turn to the VA for "free" care of ailments or injuries occurring in civilian life—**ailments other than tuberculosis and neuropsychiatric conditions.** These are the cases which the AMA believes should become the responsibility of either the individual veteran or his community.

According to the latest data available from the Veterans Administration—supplied in June, 1954 — patients with non-service-connected disabilities accounted for 62.4 per cent of the daily patient load and 84.3 per cent of all the discharges in VA hospitals in 1952. Those figures, incidentally, were confirmed as correct by Mr. Harvey V. Higley, VA Administrator, in a telegram to the AMA on October 6, 1954.

The vast majority of the non-service-connected cases each year involve general medical and surgical conditions, as distinguished from tuberculosis and mental disease. In the 1951 fiscal year, for example, more than **76 per cent** of all the patients discharged had been treated for general medical and surgical ailments which had no relation to the time spent in military service.

This is the situation to which the AMA objects. The original purpose of the VA program was to care for veterans who became physically or mentally disabled in the course of their duty to the nation—**not** to provide "free" lifetime care for any and all veterans who ever wore a uniform. Now that we have more than 20,000,000 veterans in this country—and now that the VA hospital and medical program is costing around three-quarters of a billion dollars each year—the AMA feels that the time has come for a change in the legislative policy governing the VA program.

Here, very briefly, is the reasoning behind the AMA position:

1. The present VA policy on non-service-connected cases is creating two classes of citizens—those who once wore a uniform and those who did not. As our World War II Commander-in-Chief, the late President Franklin D. Roosevelt, said in 1934: (I quote.) ". . . no person, because he wore a uniform, must thereafter be placed in a special class of beneficiaries over and above all other citizens. The fact of wearing a uniform does not mean that he can demand and receive from his Government a benefit which no other citizen receives." (Unquote.)

2. The huge, ever-growing cost of the VA program is increasing the tax burden on all citizens, **including veterans themselves,** and that cost will **skyrocket** in the years ahead unless there is a change in our policy. Apropos of this point, former President Harry Truman, a veteran and fellow Legionnaire, had this to say in May of 1952: (Again I quote.)

"I have pointed out several times in the past my belief that our first obligation to our veterans is to care for those who have disabilities resulting directly from their service to their country. Fi-

nancial assistance to veterans with non-service-connected disabilities on the other hand, should be put as soon as possible on the same basis as financial assistance payable to the non-veteran of our population.

"World War II left us with over 19,000,000 veterans. World events since then mean that hundreds of thousands more will be added each year. At the same time, we have expanded and perfected our social security laws so that they now protect most of our people. The consequences are obvious. Thousands upon thousands of veterans and their families have entitlement to Government payments under both laws. **This is confusing, wasteful, too hard to understand.**

"I strongly urge the Congress to authorize at this session a complete study of our veterans benefits programs and their relationships with our social insurance and other general welfare programs." (End of quote.)

3. The VA program is expanding government control over the nation's medical care system and is providing a big entering wedge for a complete federal health program covering the entire population—**the very thing which the American Legion has so staunchly opposed.**

4. The VA program is siphoning off personnel funds and facilities needed for the health protection of all the people, including veterans and their families in their home communities.

I urge you, fellow Legionnaires, to give careful consideration to the AMA policy—and especially to the principles which lie behind that policy. For those principles involve long-range implications which are common to many other issues facing our country in this era of the welfare state. At the same time, I also urge my colleagues in the medical profession to try for maximum understanding of the Legion's viewpoint on this issue.

However, regardless of whether we ever reach complete agreement on the subject, let's keep our discussion at the level we now have attained—the level where informed, reasonable men sit down around a table and strive for areas of agreement. Let's keep out personal bitterness and recrimination. **Let's not make it impossible for our two groups to cooperate on the many common objectives which we share.**

The American Legion and the American Medical Association should be working together in the fight against communism and all other subversive influences. We should be working together to defend and improve the free enterprise system, and to build a positive understanding of Americanism. We should be working together for national defense, better health, child welfare and any other goals designed to bring about sound, evolutionary progress within the framework of American democracy.

We also should remember that one of the prime techniques of communist subversion is to propagate class hatred—to create and promote argument and dissension — to pit one group against another for the purpose of undermining national unity. **It would indeed be tragic if the American Legion and the American Medical Association—two of the nation's most influential and patriotic organizations—should allow themselves to become pawns in the communist game of "divide and conquer."**

So, as Commander Collins told the AMA in Miami: (And I quote him for the last time.) "Let us make certain that nothing ever comes between us to imperil this essential unity of purpose and action." (End of quote.)

Let's be "citizens first, and doctors and veterans second."

NOTICE OF A COURSE IN THE CLINICAL PATHOLOGY AND PATHOLOGY OF PARASITIC DISEASES

A short intensive course on the laboratory diagnosis and pathology of parasitic infections will be presented August 15-27, 1955, at the Louisiana State University School of Medicine in New Orleans.

The course is designed primarily for pathologists and technologists. However, general practitioners, internists, pediatricians, gastroenterologists and physicians engaged in the practice of public health and tropical medicine who are interested in the laboratory diagnosis of parasitic infections are welcome to attend. The instruction and training will be of assistance to pathologists who are preparing for board examinations, to pathologists and physicians who are responsible for the diagnosis of parasitic infections in their laboratories and to technologists engaged in this specialty.

Registrants should bring their microscopes, equipped with mechanical stages, and their microscope lamps. A limited number of places will be available. The fee for the course is $50.00.

Write to Clyde Swartzwelder, Department of Microbiology, 1542 Tulane Avenue, New Orleans 12, Louisiana.

ANNUAL COMMITTEE REPORTS

PUBLIC HEALTH

BEN N. SALTZMAN, Chairman

The Committee on Public Health is a new committee, created to embrace several sub-committees that concern themselves with public health. The Sub-Committees are as follows: Sub-Committee on Rural Health, Sub-Committee on Maternal and Child Welfare, Sub-Committee on Industrial Health, Sub-Committee on Tuberculosis, Sub-Committee on Mental Health, Sub-Committee on Liaison with the State Board of Health, and Polio Advisory Sub-Committee.

These sub-committees have functioned separately this year, and in many instances have functioned well. Their reports are presented separately.

SUB-COMMITTEE ON RURAL HEALTH

BEN N. SALTZMAN, Chairman

The Sub-Committee on Rural Health has this year, as in the past several years, concerned itself chiefly with the promotion of a Rural Health Conference for Arkansas. This committee is composed of the following: Tasker N. Rodman, M.D., Leachville; W. H. Pruitt, M.D., Camden; Duane E. Brothers, M.D., Ozark; John T. Herron, M.D., State Health Dept., Little Rock; Robert F. Hyatt, Jr., M.D., Monticello; and Ben N. Saltzman, M.D., Mountain Home, Chairman.

The Advisory Committee this year consisted of the following: Charles R. Henry, M.D., Council on Rural Health, American Medical Association, Little Rock, Chairman; W. R. Brooksher, M.D., Ft. Smith, President, Arkansas Medical Society; Aubrey D. Gates, Field Director, Rural Health Council, American Medical Association; C. A. Vines, Associate Director, Agricultural Extension Service, University of Arkansas; Kenneth S. Bates, Assistant Director, Agricultural Extension Service, University of Arkansas; Miss Helen Robinson, Health Education Specialist, Extension Service, University of Arkansas; Mrs. Hazel C. Jordan, State Home Demonstration Agent, Extension Service, University of Arkansas; Waldo Frasier, Executive Secretary, Arkansas Farm Bureau Federation; John T. Herron, M.D., State Health Officer; Mrs. Mason G. Lawson, President-elect, Woman's Auxiliary to the American Medical Association; Mrs. Hoyt Choate, President, Woman's Auxiliary to the Arkansas Medical Society; Mrs. J. B. Crawford, Chairman, Rural Health Committee, Auxiliary to the Arkansas Medical Society; William Cloud, D.D.S., Arkansas Dental Association; Bryant B. Pate, D.D.S., Arkansas Dental Association; Maurice J. Friedman, D.D.S., Arkansas State Dental Association; and Mrs. R. B. Maxwell, President, Arkansas Council of Home Demonstration Clubs.

This group of both lay and professional people worked exceptionally well together this past year in formulating plans for the Rural Health Conference and in analyzing the material gleaned from the conference. On July 20 and 21, 1954, the Fourth Annual Arkansas Rural Health Conference was held in Little Rock, at the Marion Hotel. It was sponsored by the Arkansas Medical Society, and co-sponsored by the Agricultural Extension Service, the Arkansas Council of Home Demonstration Clubs, the Arkansas Farm Bureau Federation, the Arkansas State Dental Association, The Arkansas State Board of Health and the Woman's Auxiliary to the Arkansas Medical Society.

The attendance was noteworthy in that of a total of 473 registrants, there were 48 physicians present, or a little better than 10 per cent. Of the 75 counties in Arkansas, 70 were represented by other professional or lay people, or both. The groups represented were the Arkansas Medical Society, the Arkansas Dental Society, the American Medical Association, Blue Cross-Blue Shield, the Extension Service, the Farm Bureau, the Health Council, Home Demonstration Clubs, State Nurses Association, Nurses, Public Welfare, State Department of Education, Dental Auxiliary, International Foundation for Youth Education, Business and Professional Women, and visitors. In all, 20 organizations were represented.

The theme of the program was "Putting 'U' in Community." It was well carried out in the program, which follows:

Dr. W. R. Brooksher, President of the Arkansas Medical Society, gave the address of welcome. C. A. Vines, Associate Director, Agricultural Extension Service, University of Arkansas, was the key-noter, with a talk on the theme, "Putting 'U' in Community." Dr. Robert Hyatt, of Monticello, a member of the Committee on Rural Health, spoke on "Community Responsibility for Its Aging Population." A panel of experts, including Dr. Ewing W. Crawfis, Superintendent, State Hospital for Nervous Diseases; Dr. William B. Hawkins, Assistant Chief of Professional Service, Veterans Hospital, North Little Rock; Mrs. Scotta S. Sheets, Supervisor, In-Service Training, State Welfare Department; Carlos J. Smith, Administrator, Helena Hospital; Mrs. Sarah M. Dilley, President, Arkansas State Association of Licensed Nursing Homes; and Moody Moore, Division of Hospitals, State Health Department, served as experts in the discussion that followed. Ben N. Saltzman, M.D., Mountain Home, acted as discussion leader throughout the program.

The evening program consisted of a film on "Jugs," a junior group acting as nurses aids, and a short talk by Mrs. W. G. Cooper, Chairman, Arkansas State Nurse Recruitment Council, Little Rock. The speaker of the evening presented an inspirational talk on "Americanism." He was Jeff Williams, of Chickasha, Oklahoma.

The next morning, Mrs. Howard Stern of the Woman's Auxiliary to the Arkansas Medical Society, Pine Bluff, delivered a message concerning the "Available Health Resources in Arkansas." J. H. Wasson, State Supervisor for Rural Education, spoke on "Community Responsibility for School Health," and presented a panel of experts which included Louis K. Hundley, M.D., Pine Bluff; Maurice Friedman, D.D.S., Little Rock; Cecil E. Shuffield, County Supervisor of Nashville; Mrs. S. H. Carter, Teacher in Public Schools, Mountain Home; Mrs. J. A. Collins, President of P.T.A., Texarkana; Mrs. Robert Thompson, Chairman, Health and Safety Committee, Arkansas Council of Home Demonstration Clubs, Rison; Mrs. August Lueker, Farm Bureau Women's Committee, Pope County, Russellville; and W. F. Pefferkorn, Sanitarian, Pine Bluff.

Following a discussion, the meeting was summarized by Aubrey D. Gates, Field Director, Council on Rural Health, American Medical Association.

A series of exhibits were presented by the State Health Department, Arkansas Dental Association, Blue Cross-Blue Shield, Arkansas State Nurses Association, Arkansas League for Nursing; Woman's Auxiliary to the Arkansas Medical Society, Arkansas Practical Nurses Association and the University of Arkansas School of Medicine.

The cost of printing the programs was borne by the following: The William T. Stover Co., Inc., Central Surgical Co., Inc., Dick X-ray Co., Keleket X-ray Company of Arkansas, Arkansas Dental Association, and the Arkansas Medical Society. The expenses of the conference fell well within the budget to which the committee was limited.

Following the conference, many favorable expressions were received from over the entire State, indicating a profound interest in the continuance of this program.

The committee and Advisory Committee met soon after the conference to determine the procedure for the following year. It was decided that Rural Health work could best be furthered by a continuation of the annual Rural Health Conferences in its present form. Plans were made for the Fifth Annual Conference to be held, Tuesday and Wednesday, June 28 and 29, 1955. A tentative program was outlined. Many members of the committee and Advisory Committee plan to attend the National Rural Health Conference in Milwaukee, Wisconsin, on February 24, 25, and 26, 1955.

The writer attended a meeting of the Southeastern States Rural Health Committee Chairmen and State Presidents in Miami, Florida, at the time of the AMA Interim Session. Much information of value was obtained at this meeting, and will be incorporated into future Rural Health Committee work. The Committee on Rural Health is open to all suggestions from members of the Medical Society, as to its program in the future.

SUB-COMMITTEE ON MENTAL HEALTH

E. H. CRAWFIS, Chairman

In July, 1954, President Brooksher appointed a Sub-Committee on Mental Health, consisting of Dr. E. H. Crawfis, Chairman; Dr. William G. Reese, and Dr. John B. Kirkley. This is a sub-committee of the Committee on Public Health.

There was a National Meeting on Mental Health held at the Headquarters of the American Medical Association in Chicago on September 17-18, 1954. Members of the Committee on Mental Health of the State Medical Society were invited to this meeting. The general purpose of this meeting was to discuss methods of gaining a more effective integration of the techniques of psychiatry with general medical practice. Unfortunately, because of prior commitments, none of the members was able to attend this meeting and Arkansas was not represented.

Dr. John B. Kirkley notified us that he was reporting for active duty with the Army and would be unable to serve on the committee. Dr. Brooksher appointed Dr. Robert F. Hyatt to replace Dr. Kirkley.

This committee has been active in two surveys on mental health here in the State of Arkansas. Dr. Crawfis and Dr. Reese participated in a survey on Mental Health Training and Research in the Southern States. The survey was confined to specific categories of mental health personnel, namely, psychiatrists, clinical psychologists, psychiatric social workers, and psychiatric nurses. Following the states' surveys, a Regional Conference was held at Atlanta on July 21-24, 1954. This survey established that the Southern States are sadly deficient in trained personnel in these categories and that in order to develop effective mental health programs in the South, it will be necessary to develop training programs, as well as research programs. The conference recommended that consideration should be given to the establishment of regional arrangements for training facilities. Since the Southern Regional Education Board has been highly successful in regional arrangements in other areas, it was suggested that the states should establish a Southern Regional Council on Mental Health Training and Research to work with the Southern Regional Education Board in developing arrangements and programs.

Early in 1954, Governor Cherry set up a committee to study the over-all mental health needs and resources of the State of Arkansas. This committee, with the professional assistance of the American Psychiatric Association, was to collect the existing information on the mental health needs in the state, as well as the resources available to meet these needs. This sub-committee participated in this Arkansas Mental Health Survey in two ways. Again Dr. Crawfis and Dr. Reese served as members of the committee. It should also be mentioned that Dr. Louis Hundley served as a member of this committee. As a part of the activity of the survey committee, a public forum on Arkansas' mental health needs was held at Little Rock in the State Capitol on October 1-2, 1954. At this Open Forum Mr. Paul C. Schaefer presented a formal statement covering some of the significant needs and recommendations in this particular field as contemplated by the medical profession generally. Mr. Schaefer spoke as the official representative of the Arkansas Medical Society and his statement was developed after conferring with members of the Sub-Committee and Dr. Brooksher.

On Sunday, October 31, 1954, the Sub-Committee participated in the special session of the Arkansas Medical Society held here in Little Rock. We supported a proposal to amend the Medical Practice Act so as to include the diagnosis and treatment of mental and nervous diseases and disorders. This change was originally proposed by the Arkansas Psychiatric Society and was contained in a resolution by that organization to the Arkansas Medical Society. This amendment was considered favorably and will be included in the legislative program to be presented to the Legislature by the Legislative Committee.

The sub-committee anticipates that it will be active during the coming session of the Legislature since there will be a number of problems relating to mental health coming before the Legislature. We will continue to work with other committees and representatives of the Arkansas Medical Society in an effort to obtain an adequate mental health program for the State of Arkansas.

POLIO ADVISORY

E. H. CRAWLEY, Chairman

The Polio Advisory Sub-Committee respectfully submits its report, of its activities and the accomplishments to date. Due to incomplete phases of our work an addition must be made at a later date.

This committee was first formed in 1955 and President Brooksher appointed the following members: Dr. Eugene H. Crawley, Chairman; Dr. James T. Rhyne, W. H. Pruitt, Katherine Dodd, and John Hundley. The first meeting held was November 14, 1954, in Little Rock, with the following members present: Drs. Crawley, Dodd, and Rhyne; non-members, Dr. Albert Engelbach, medical consultant, N.F.I.P., and Mrs. Louis Hundley.

The purpose of our committee was established; to give better and more efficient care to Polio cases in coordination and cooperation with the N.F.I.P. and all other state and private agencies actively caring for or aiding in the problems of this disease by:

I. Education.

(a) Aid in educating the public as to the nature and treatment of polio, and prevention by providing cooperating in educational programs wherever possible.

(b) Organize and conduct a program to give physicians the latest information on the diagnosis and treatment of Polio through:

(1) Programs in the local and county societies in the form of speakers and panels.

(2) Provide a list of consultants to aid local physicians. A list of physicians willing to serve as consultants be given to the State N.F.I.P. office for the reference of their local representatives and physicians on a local level.

II. Cooperate on committees and in convergence with the N.F.I.P. and the state agencies and departments concerned with the problem.

(a) Provide a revised fee schedule to improve relations with the N.F.I.P. and state agencies. It was a strong feeling of some members of the committee that the fees were in need of revision and more opportunity allowed for payments by the patients and the N.F.I.P. acting as an aid.

(b) Aid in the evaluation of long term cases when presented by local physicians and agencies for consideration where there are special problems of physiotherapy, nursing home, respirator and other specific problems requiring technical procedures.

(c) Encourage the organization of local medical advisory committees to aid in local problems. The committee urges and recommends that every county have such a committee.

(d) Acquaint physicians and local Polio chairman with the facilities available for care of polio patients in Arkansas. The committee urges and recommends that every local hospital and local medical society take care of their own polio cases. This not only the feeling of this committee, but is consistant with the recommendations of the public health department, American Hospital Associations and leading medical authorities on the disease. It is our joint belief that many polio patients are definitely harmed and even are lost, because of long ambulance rides and other hardships associated with transporting acutely ill patients, especially respiratory cases. Physicians and hospitals should be made aware of their obligations of service to their patients as well as the medicolegal responsibility they both carry.

(e) Due to changes in the policies of the N.F.I.P. and the lack of clarification of the regulations of the Crippled Children's Division of the Welfare Department it is necessary to restate these policies and regulations in order that the status of patients being cared for by one or the other will be clear and the two services can work together and not duplicate each other on some patients. Both agencies have agreed in the future to watch for and avoid overlapping and endeavor to coordinate and cooperate in their services.

III. Cooperate with the State Health Department and the State Department of Education in organizing the state schools to administer the Salk Vaccine if it is made available in 1955.

(a) The chairman of this committee has sat in a joint committee of the education and health department representatives in formulating the plans for the vaccine. It was felt that all existing agencies should be used and no new ones developed. Therefore, the problem has been approached through the county school administrators, county health officers and presidents of the county medical societies.

In summary the following plan is to be followed:

(1) The plan is to be presented to the local committees for their own organization ahead of time. All interested groups are to be given their respective duties before April.

(2) Announcement of the acceptability of the vaccine.

(3) The vaccine plan as set up by the combined committee is to be followed as outlined.

I. The pre-vaccination phase: this consists of the planning committee setting up its plans for obtaining the vaccine. The schools will receive request slips for the parents approval and compile rosters of accepted children and the preservation of those records for possible booster injections. The explanation of the vaccine must be clear by the physicians and informed laymen.

II. The vaccination phase: This phase will consist of organizing the schools for clinics, the organization of clinics at central points, and the actual giving of the vaccine. The clinics will be organized on a local or county basis as the local authorities consider most expedient. The vaccine will be given by local personnel, but help may be necessary in certain areas, where there are no local trained personnel, such as physicians and nurses.

The local medical societies and Polio foundation chapters will be responsible for equipment of the clinics such as needles, syringes, cotton, etc.

The vaccine will be supplied by the National Foundation for Infantile Paralysis through the State Board of Health office and will be made available through the respective County Health Offices.

III. The post-vaccine phase: will consist of the preserving the records by the school and the state health department for reference medicolegal purposes and for booster injections which will probably be necessary.

This committee has now plans to be drafted for a suggested Clinic organization to be followed as a guide that may be adapted for local use with allowances for liberal alterations where the local committees consider them necessary. It has been the policy of all committees in this program to offer suggestions but to avoid any dictation ironclad rules to local groups in an effort to utilize and stimulate local initiative so much as possible. But where it does not exist we hope to be of service and be able to see that every child who is eligible, and wants it, can receive this vaccine.

Due to the urgency of the vaccine plans this committee has not been able to pursue other phases of this great problem but as time permits and conditions are suitable we plan to act with the support and cooperation of all members of the society.

Further addition will be necessary for publication at later dates.

THE AMERICAN MEDICAL EDUCATION FOUNDATION

W. R. BROOKSHER, Chairman

America's medical schools graduated 6,681 physicians in the year 1953-1954; they attained an enrollment of 28,227 medical students and they enrolled 7,449 students in the freshman class, all records over any previous year. The funds raised by the American Medical Education Foundation were of material assistance in the achievement of these records. 18,126 contributors gave $1,098,962 to the Foundation during the year. Of this $500,000 was a contribution of the American Medical Association and $190,000 came from the assessment program of the Illinois State Medical Society. An additional $1,231,000 was contributed directly to medical schools by physicians and did not count in the total of the Foundation.

The physician's responsibility to medical education is peculiar; no. only did he receive his training from these schools but because these schools remain a bulwark of freedom. Their progress has been great because of the lack of governmental or other controls which would tend to hamper their academic freedom without which they could not successfully function. While the profession generally has given increasing support to the activities of the Foundation, there is need for both dollars and effort from the physicians of the United States.

During the year Arkansas physicians and the Auxiliary contributed $1,150.50 to the Fund. The University of Arkansas School of Medicine received from the Foundation $24,164.00.

It is hoped that individual members of the Society will make continued and generous contributions during 1955-1956.

CANCER CONTROL

C. A. ARCHER, JR., Chairman

The Cancer Committee of Arkansas Medical Society met in Little Rock on January 22nd, 1955.

Two Cancer Education Programs have been presented in the past year; one in Monticello and one in El Dorado. These programs endeavor to give the doctors over the State the over all program of the combined Cancer groups in Arkansas.

The Committee has scheduled similar programs for this year in Southwest Arkansas (District Meeting), Northeastern Arkansas and in Fayetteville.

INDUSTRIAL HEALTH COMMITTEE

H. E. MOBLEY, Chairman

The Committee on Industrial Medicine and Surgery acted as co-sponsor with the Arkansas Academy of General Practice with the cooperation of the Akansas School of Medicine to hold a postgraduate course of Industrial Medicine. The course was given on October 12 and 13, 1954, at the School of Medicine. The Committee felt that the course was well attended and that much benefit came out of it.

The Industrial Health Committee of the Arkansas Medical Society met in conjunction with the Medical Arbitration Commission on Sunday, December 5, 1954. The Arbitration Commission gave a report of its activities. The members of the Arbitration Commission also discussed some of the difficulties and problems with which they had met and stated that they thought it was necessary to have some changes in regulations.

Motion was made, seconded and passed that it be recommended to the Council of the Arkansas Medical Society that the Arbitration Commission be given authority to set up rules governing its methods and other details of operation. It was felt by the Committee that the Arbitration Commission being formed from the Arkansas Medical Society and from the Claims Managers Council was not directly subject to the action of either of these organizations and therefore should set up its own rules of procedure.

At the meeting, it was the opinion of the Committee that the postgraduate course of industrial medicine had been very successful and felt that future courses should be conducted. It was also thought that perhaps it might be well to conduct some of these programs at the Councilor District's level. In view of this opinion, a committee was appointed to study and plan for the future in regards to such matters. This committee was composed of Dr. N. B. Daniel, Chairman; Dr. Frank Padberg and Dr. John Olson.

COMMITTEE ON TUBERCULOSIS

JEROME S. LEVY, Chairman

The Committee on Tuberculosis met on two occasions, once at McRae Sanatorium and once at Booneville. The purposes of this Committee were discussed and a program in keeping with these purposes as defined in the Constitution and By-Laws of the Arkansas Medical Society was set up. In order to do this the functions of the two Sanatoria and of the State Board of Health were outlined by the representatives of these institutions who were present. The major problems discussed were those of the recalcitrant patient, the lack of finances for the tuberculosis control program, and the disinterest of the local private physician in the problem of tuberculosis.

The recalcitrant patient presents one of the most difficult problems to us. There is a difference of opinion concerning the best method to deal with it. Several factors enter to make a recalcitrant patient; i.e., the one who refuses to place himself under proper care either at home or at the Sanatorium, remaining a menace to public health. Too few patients who enter the hospitals have been prepared prior to entry for the economic adjustment which is necessary in order to profit most by their treatment. A social adjustment of the patient and family is necessary due to the absence of the patient from the home. The emotionally unstable, in which class is the alcoholic and the psychopathic personality, are prominent factors in the making of a recalcitrant patient. The Committee spent hours of discussion of this problem. It was generally thought that this patient should be forced to undertake treatment but there was also reluctance by some to place these individuals in the Sanatoria. The reluctance was based on the assumption that this would destroy the voluntary system now in vogue, make criminals out of the sick, and put the staff in the position of being jailors. The inability to provide a ward under lock and key was a major factor and funds are unavailable to construct a locked ward or unit.

The Committee finally recommends that these patients be sent to the Sanatoria by court order and treated in the same manner as is the tuberculosis convict. The Staffs of the hospitals are not considered jailors in the management of these patients. The plan would work in this manner: The patient would be committed. He would be treated as any other patient and, unless he

himself would announce it, none would know he had been sent to the hospital by legal proceedings. Should he not be co-operative or should he leave the Sanatorium against medical advice, the State Health Officer would be notified who, in turn, would notify the State or Local Police to arrest the patient. In an agreement with Dr. Crawfis, this patient would be placed in the tuberculosis unit of the State Hospital for Mental Diseases for a two or three weeks period of observation for mental illness and for further indoctrination of the proper attitude towards his treatment. If found to be without mental illness, he would be sent again to the Tuberculosis Sanatorium. The Superintendent of the Sanatorium agrees to accept back this patient. The Committee is of the opinion that this procedure would work very satisfactorily and recommends this be tried. It is thought that some law giving the State Health Officer this authority and setting up a court proceeding for the commitment of the recalcitrant patient is necessary. Your Committee is pursuing further the ramifications of this problem and will continue its studies with the hope of solving it.

At its meeting at McRae Sanatorium the work there was reviewed and the Committee wishes to commend Dr. Hughe Browne for the excellent program he has established and for the manner he has carried it out.

The Committee wishes to recall to the members of the State Medical Society the availability of the State Health Department, its Division on Tuberculosis Control, and the Hygienic Laboratory in helping you to establish or disprove the presence of active tuberculosis in your patients, especially those who are unable to pay for these services. After a suspicious X-ray has been seen and the patient referred to the local physician, a 14x17-inch film should be made and laboratory investigations carried out. Sputum specimens and gastric washings can be examined and cultured at the State Hygienic Laboratory if your patient is unable to pay for this in a private laboratory. Contact your local Health Officer or the State Health Officer for help. Our survey emphasized the lack of interest in tuberculosis exhibited by the majority of the physicians throughout the State. The ease with which it is possible to send a patient to either of the State Sanatoria has made many of us lose interest so that we automatically send these patients to Booneville or Alexander. Many can now be treated in their home with the use of the newer antibiotics and other drugs. The failure to definitely establish the diagnosis and the prompt use of the newer drugs available may be unwise. Your Committee strongly recommends that the Program Committee of the State Society include on the annual program each year speakers on tuberculosis, its diagnosis and its management in the home. The full cooperation of the National Tuberculosis Association, the American Trudeau Society, and your State Tuberculosis Association is available to send outstanding speakers who are authorities in this field to our annual meetings, and to hold clinics, seminars, or a post-graduate course for the local physician working on the local level. We recommend that these sources of help be used.

The problem of the payment for pneumoperitoneum by the State in the same manner as payment for pneumothorax was explored and your Committee recommends that a law be passed to accomplish this. We have been informed that the Comptroller has expressed the opinion that the State Welfare Board has full authority in its enabling act to pay for this service and a change in the law is not necessary. The Superintendents of the Sanatoria are empowered to approve bills for pneumothorax and could do so for pneumoperitoneum according to our source of information.

Your Committee wishes to call your attention to the program of Jefferson County. There is a high percentage of active tuberculosis in the colored population. Open cases have had to wait for long periods of time for admittance at McRae due to its crowded state. Through the cooperation of the County Medical Society, the Local Health Officer and the County Tuberculosis Association, these cases are being treated in their home after the diagnosis is established. The local health nurse visits these patients twice a week to give them Streptomycin. They take the prescribed amount of Isonicotinamide Hydroxide or other drugs. When necessary the local social service worker enters to assist in the adjustment these individuals must make. A large majority are non-infectious by the time they can be admitted to McRae. This is a program your Committee can recommend to you for establishment in your own Community.

The reduction in Federal funds forces the local governments to assume this responsibility. This is actually an obligation of the individual Communities. The need to meet this obligation must be understood and this gives all of us an opportunity to educate the people of our own State that Tuberculosis remains a problem, that through lay and professional cooperation it can be eliminated, and that the funds for case finding and care must be made available locally. It gives us added opportunity to demonstrate our ability to meet such problems without Federal Aid, answering the argument of Socialized Medicine. We urge your support in meeting this problem.

The problem of tuberculosis remains with us. It has not been licked as so many are inclined to think. Last year we had 1,500 new cases reported. Deaths from tuberculosis remain well above the national average. Last year 383 deaths were reported from tuberculosis in the State of Arkansas. Your Committee is continuing to study this problem and will have further reports for you. A preliminary report was made to the special meeting of the House of Delegates last November.

LIAISON WITH STATE BOARD OF HEALTH

T. N. RODMAN, Chairman

There has been nothing brought to the attention of this Sub-Committee concerning the State Board of Health.

SUB-COMMITTEE ON POSTGRADUATE EDUCATION

J. M. KOLB, Chairman

The Sub-Committee on Postgraduate Education met at the University of Arkansas School of Medicine on January 30, 1955. Present also by invitation were: Dr. Hayden C. Nicholson, Provost; Dr. Willis Brown, Director of Postgraduate Education, and Dr. C. G. Sutherland, Assistant to Provost and from the University of Arkansas School of Medicine. Members of the committee on Medical Education, Arkansas Medical Society were as follows: Drs. H. W. Thomas, C. C. Long, J. M. Kolb, Jack Kennedy, and John Smith. Also present was Dr. Charles Archer, Chairman of Postgraduate Education of the Arkansas Academy of General Practice.

Dr. Brown gave a resume of the work done by the Department of Postgraduate Education and of their co-operation with other committees, groups and organizations to develop Postgraduate training.

After much discussion by all present the group voted on the following:

1. To continue the Postgraduate Education as in the past, with frequent small groups, and not to try to compete with large assemblies already established.
2. Make a study of the feasibility of holding postgraduate classes in the various sections of the State, on a rotating bases.
3. To study the feasibility of having a week long Postgraduate Education meeting in the fall, with emphasis on certain subjects varying from day to day. This study to be the second week of October at which time the Arkansas Academy of General Practice would be in session.

It was decided that a decision of the last two points would be reached at the next meeting to be held in April. The meeting was adjourned at 11 a.m.

BUDGET

J. J. MONFORT, Chairman

The Budget Committee respectfully submits the following proposed budget for 1955:

Income		
Membership Dues	$26,250.00	
Journal Advertising	17,000.00	
Interest on Bonds	262.00	
Annual Session—Booth Income	2,300.00	
Annual Session—Registration	1,750.00	
Annual Session—Banquet	1,750.00	
AMA Reimbursement	250.00	$49,562.00
Expenses		
Salaries	$13,150.00	
Journal Expense	15,500.00	
Travel and Convention	4,000.00	
Telephone and Telegraph	1,100.00	
Office Supplies and Expense	950.00	
Postage	900.00	
Dues and Subscription	250.00	
Rent	1,080.00	
Taxes	180.00	
Contributions	300.00	
Annual Session	4,000.00	
Rural Health Committee	500.00	
Public Relations Committee	1,000.00	
Stationery and Printing	900.00	
Auxiliary	1,100.00	
Special Committees	50.00	
Auditing	125.00	
Miscellaneous	200.00	
Bond Premiums and Insurance	90.00	
Reserve for Legal Services	2,650.00	$48,025.00

LIAISON WITH BLUE CROSS-BLUE SHIELD

S. G. JAMESON, Chairman

The purpose of the Liaison Committee of the Arkansas Medical Society to Blue Cross-Blue Shield is to act as a medium for the exchanging of ideas and problems common to both the members of the Arkansas Medical Society and the Arkansas Blue Cross-Blue Shield Plan. This Committee met on January 27, 1955, at the Albert Pike Hotel, Little Rock.

Present: Dr. Gerald Teasley, Dr. B. D. Stewart, Dr. A. S. Koenig, Dr. Howard Stern, and Dr. Sam Jameson, all members of the Liaison Committee; Dr. Ellery Gay, Messrs. J. L. Redheffer, Rick Campbell, and Al Ercolano, representing Blue Cross-Blue Shield.

At this meeting many ideas and problems, both general and specific, were discussed, all of which apparently emphasized the fact that very few members of the Committee as well as members of the Arkansas Medical Society understand all that should be known about Blue Cross-Blue Shield, and as a result thereof, have not enjoyed the best professional relations possible, either as a group or as an individual, with this organization.

The Committee unanimously recommended the enactment of a full scale physicians relations program between members of the Arkansas Medical Society and Blue Cross-Blue Shield. It is felt that this program would be most successful if conducted with smaller groups; therefore, it is the recommendation of this Committee that the method of contact preferably be on the same date and in the same location as that of each hospital staff meeting. To comply with the regulations of the Joint Commission on Accreditation of Hospitals, the Committee recommends that the discussion period be held entirely independent of the hospital staff meeting, preferably just before or just after the meeting. In counties where there is no regular hospital staff meeting, it is recommended that the method of contact be through county society meetings. It is further recommended that one meeting be held with each hospital group or county group every six months in order to keep well informed of new and changing problems, but only at the invitation and convenience of each hospital or county group.

The aims of these meetings would include the following:

1. To better acquaint each individual physician with the working mechanism of Blue Cross-Blue Shield.
2. To acquaint each individual physician with the problems which Blue Cross-Blue Shield encounters with regard to claims, the standardization of fees, over utilization of insurance plans, etc.
3. To acquaint Blue Cross-Blue Shield with any problems which may be peculiar to one individual or the entire medical group in that particular area.
4. To elicit new ideas from individual physicians as to methods of increasing benefits by Blue Cross-Blue Shield.
5. To improve relations between the physician, Blue Cross-Blue Shield, and the patient.

With regard to the recent organizational meeting of the Arkansas State Medical Assistants Society, this Committee recommends that the component organizations be established as soon as possible in order to allow individual contact of each medical assistant member by a representative of Blue Cross-Blue Shield. The proven willingness of Blue Cross-Blue Shield to cooperate in the organization and maintenance of the Medical Assistants Society is to be commended, as this society will eventually help each individual member of the Arkansas Medical Society by having better informed assistants, more properly completed insurance forms, and more constant contact with any problems that might arise between the physician and Blue Cross-Blue Shield.

It is further recommended that this Committee assume as part of its responsibilities the investigation of any grievance which any individual member of the Arkansas Medical Society may have with Blue Cross-Blue Shield, as well as the investigation of any grievance which Blue Cross-Blue Shield may have with any individual of the Arkansas Medical Society. It is to be pointed out that this in no way conflicts with, or takes the place of, the Grievance

Committee of the Arkansas State Medical Society. The Liaison Committee will be concerned only with problems between the physician and Blue Cross-Blue Shield.

Although this Committee does not recommend any formal contact between Blue Cross-Blue Shield and the students of the Arkansas Medical School, it wishes to commend Blue Cross-Blue Shield for the interest which it is taking in plans to inform medical students of prepaid medical plans, the problems encountered in group insurance, and the advantages of obtaining as much information as possible about group insurance as early as possible in the career of a physician. It is to be emphasized that any informal contact between students at the Arkansas School of Medicine and Blue Cross-Blue Shield is made on a voluntary basis by Blue Cross-Blue Shield and at the expense of Blue Cross-Blue Shield.

Additional suggestions from any individual member or component group of the Arkansas Medical Society which may improve the relationship of an individual physician and/or the Arkansas Medical Society with Blue Cross-Blue Shield will be welcomed.

SUB-COMMITTEE ON CIVIL DEFENSE

JOE NORTON, Chairman

The Sub-Committee on State Health and Medical Resources for Civil Defense of the Arkansas Medical Society is composed of Dr. Lawrence Drewery of Camden, Dr. Joe Buchman of Little Rock, and myself.

This committee has not met as a group, but has exchanged letters among individuals concerning our program. Considerable literature from Federal and State defense agencies has been received. From this material, we are hoping to arrive at a basic plan for organization of the doctors in each Councilor District in Arkansas, to be used in any instance requiring emergency medical care, be it war or natural catastrophe. This plan will allow at least two emergency medical teams in each Councilor District with possibly more in the more populous areas. One team would be stationed at a central hospital or a suitable central building in the district, and the other team would be sent to the scene of disaster upon notification of the State Defense office.

We also feel that consideration should be given toward establishing an annual course in the medical aspects of civil defense at our University Medical Center in Little Rock, as a part of their Postgraduate Program.

Further, we feel that all news of public interest concerning the medical aspects of civil defense should be forwarded to the local press and radio and television stations by the local medical civil defense representative, with this same effort being made constantly on a statewide level through the State Committee on Civil Defense and through the State Committee on Public Relations.

Further consideration might be given toward incorporating annually a talk on the medical aspects of civil defense in the program of our state Medical Society, utilizing the outstanding authorities available to us.

SCIENTIFIC PROGRAM FOR ANNUAL SESSION OF ARKANSAS MEDICAL SOCIETY

ALFRED KAHN, Chairman

Your Committee on Scientific Program for the annual session has endeavored to give you a well rounded, interesting scientific program. Great stress was laid on trying to make the program interesting, informative, and accurate. In order to accomplish this, the program consists of participants from out of the state as well as members of our own organization.

The out-of-state participants are men who are widely known in their respective fields, and have distinguished records in teaching and research. The Committee feels particularly pleased to be able to get a group of excellent practicing physicians from within the state to participate on this program, too. The latter group has a wide geographic distribution throughout the state.

Your Committee wishes to express its thanks to a group of members from various communities who have agreed to help us conduct the program; this includes organizing informal meetings, presiding at luncheons and presiding at meetings.

All of this Committee hope that the Program will meet with your hearty approval.

ARRANGEMENTS FOR ANNUAL SESSION

H. KING WADE, JR., Chairman

Inclosed is a report of Committee on Arrangements for Annual Session, per your request. Definitely the situation appears to be "well in hand." As you know, many of our Program Chairmen have been working directly with you in our office, pertaining to such matters as scientific exhibits, commercial exhibits, etc.

The Entertainment Committee is arranging what we believe will be, a thoroughly enjoyable program for our doctors and their wives. We would certainly recommend to all that they bring their bathing suits and fishing gear to Hot Springs with them in May, as they may have the opportunity to indulge in both swimming and fishing on one of the parties that we have planned.

We have encountered no particular major problems, and we have had excellent cooperation from the management of the Arlington Hotel in all our dealings with them.

We realize that with five months yet to go, various problems will be arising from time to time, and we do not feel that they will be any that cannot be handled with a minimum of trouble.

ADVISORY COMMITTEE TO ADVISORY SERVICE

GERALD TEASLEY, Chairman

During 1954 the Arkansas Selective Service System was requested to induct 14 physicians of all priority groups. In addition to this 14, 11 physicians who were Selective Service registrants were commissioned and called to active duty. At the present time there are eight physicians under orders to report for active duty on March 30, 1955. It is not known what will be the future of the Medical Advisory Committee because the present Doctor Draft Law expires in June, 1955. With the recent activity in the East, it is entirely possible that the Doctor Draft Law may be continued; however, there is no information available to be certain that this is true. At the present moment, February 1, 1955, there are no calls pending for

physicians to report for active duty. It is not known when another call may be made, and prior to report of this letter additional action may have to be taken by the Committee.

REPORT OF THE STATE MEDICAL BOARD OF THE ARKANSAS MEDICAL SOCIETY

JOE VERSER, Secretary

The Secretary of the State Medical Board makes the following report of the activities of this Board since the last meeting of the Arkansas Medical Society.

The officers are as follows: Dr. G. D. Murphy, Jr., president; Dr. M. L. Harris, vice-president; and Dr. Joe Verser, secretary-treasurer. Drs. H. J. Hall, Frank M. Burton, Jeff Baggett and Wm. A. Snodgrass, Jr., members.

The Board investigated every case of violation of the Medical Practice Act reported to the secretary during the year. One court conviction was obtained and the person involved was given a penitentiary sentence for practicing medicine without a license.

Last year the secretary wrote the Attorney General asking that his office make an investigation relative to Jacob S. Schirmer, Corning, Arkansas, who supposedly held license from the State Eclectic Board. Charges were filed in Circuit Court against Schirmer by the Attorney General, and in June of this year Schirmer's license was permanently revoked by the Circuit Judge. Much credit must be given to Attorney General Tom Gentry and Attorney Gene Warren for this outstanding work.

The Board approved the proposed law to abolish the three existing state boards and create one state board of Medical Examiners. We believe this is a step forward toward an ideal Medical Practice Act.

A yearly financial report of the Board's activities, as prepared by Winter, Johnson and Company, C.P.A. Accountants, was sent to and approved by the Council of the Arkansas Medical Society.

Following is a report of the Board's proceedings—February 1, 1954—February 1, 1955.

Physicians Registered for 1955:

Resident	1,237
Non-Resident	434
Physicians licensed by examination	72
Physicians licensed by reciprocity	38
Physicians certified to other states	81
License revoked for non-payment of annual registration fee	Incomplete
License suspended for non-payment of annual registration fee	Incomplete
Physicians placed on probation for violation of Federal Narcotic Act	5
Court conviction obtained for violation of Medical Practice Act	1
Cases pending for violation of Medical Practice Act	1

Following is a financial report covering the period February 1, 1954, to February 1, 1955. A yearly audit by a Certified Public Accountant will be made in June, 1955.

Cash on hand—Feb. 1, 1953		$17,710.12
Bonds—Series E, purchase price		6,000.00
Collections from the following:		
Registration Fees	$5,629.20	
Reciprocity Fees	1,950.00	
Certification Fees	1,045.00	
4-year Exam. Fees	1,050.00	
Final Exam. Fees	370.00	
Primary Exam. Fees	855.00	
Duplicate Certificates	5.00	
Directories Sold	3.50	
Physical Therapy Fees	105.00	11,012.70
Total		$34,722.82

Expenditures:

Salary—Sec'y & Expense of Board Members	$ 5,425.53
Attorney's Fee & Travel Expense to Meetings	3,545.00
Office Rent	180.00
Dues of Federation of State Board of U. S.	50.00
Office Expense—Printing, Tele., Bond, Postage, frt., stationery and withholding & F.I.C.A. taxes	2,088.29
Refunds	37.00
C.P.A. Audit	150.00
Investigations—Pinkerton Detective Agency & Bailey & Warren	1,526.65
Equipment	259.75
	$13,262.22

Total Expenditures	$13,262.22
Bonds on Hand	6,000.00
Cash Bal. in Bank, Feb. 1, 1955	15,460.00
	$34,722.82

ANNUAL REPORT OF STATE HEALTH DEPARTMENT

J. T. HERRON, State Health, Officer

Cause of Death	No. of Deaths	Rate Per 10,000 Population
Heart	5,140	269.2
Neoplasm (cancer)	2,031	106.4
Vascular lesions affecting the central nervous system (stroke)	1,915	100.3
Accidents (all forms)	1,158	60.1
Pneumonia (all forms)	583	30.0
Nephritis (all forms)	419	21.4
Tuberculosis (all forms)	383	20.1
Unqualified immaturity (prematurity)	250	13.1
Influenza (all types)	237	12.4
Diabetes	175	9.2

43,528 births were recorded in Arkansas in 1953. This represents a rate of 22.8 per 1,000 population. In 1948 the birth rate was 27.8.

There were 15,688 deaths in 1953. This represents a death rate of 8.2 per 1,000 population. In 1948 the death rate was 8.6.

1,275 infant deaths were recorded in 1953, representing a rate of 29.3 per 1,000 live births. In 1948 the infant death rate was 27.6.

There were 39 maternal deaths in Arkansas in 1953, representing a rate of .9 per 1,000 live births. In 1948 the rate was 2.1.

Despite the lack of adequate funds to employ personnel to execute a minimal adequate public health program in the State of Arkansas, the general health of the citizens of the State is improving according to recognized public health statistics on preventable communicable diseases. This desired trend speaks well for the meager staff of state and local professional full-time public health workers, the cooperation of private practicing physicians throughout the State, and certain advances in preventive and curative medicine.

The trend of Federal reduction to the states in grant-in-aid funds combined with the State's not providing funds adequate to support a really protective public health program, has resulted in a real shortage of professional personnel to carry out a minimal adequate program based on population needs according to nationally accepted standards. According to these standards and the actual need in Arkansas we are short the following full-time local public health personnel at the very least: 20 physicians; 5 engineers; 150 nurses; 3 public health educators; 25 sanitarians; 26 clerical workers.

Since 1949 Federal public health funds to the State have been reduced by fifty-one percent. State and local funds have not been increased to offset this loss. Should this trend continue, we will never reach the modest goal of rendering minimal adequate public health services unless some definite plans for relief are executed within the State. Local units of government are realizing the seriousness of this situation and are beginning to provide additional funds in support of the program.

At the present time and in years to come, if Arkansas is to establish and maintain in the seventy-five counties of the State an adequate number of local health departments capable of rendering adequate services to protect the health of its people, adequate funds must be made available through one or all of the following sources: (1) Increased appropriations through the General Assembly; (2) increased county and city appropriations; (3) increased Federal grant-in-aid public health allotments.

Morbidity reports indicated another healthful year for Arkansas people. There were some of the acute infectious diseases that had a slightly higher incidence than the previous year, such as chicken-pox, mumps, whooping cough, poliomyelitis, and typhoid fever. All of these except typhoid fever vary considerably in incidence from year to year and occur in epidemic cycles every few years. Typhoid fever reached a low in 1951 in this State but has gradually climbed upward each year since, from 82 in 1951 to the 131 cases reported in 1954. It will be of interest to note an interruption of this upward trend which it is hoped will soon come about. Streptococcal infections including scarlet fever indicated a sharp rise in 1954 over 1953 from 1,998 to 3,046 cases.

The major activity of the Communicable Disease Control Division during the year was the poliomyelitis vaccine field trials in five counties. Preliminary arrangements and follow-up on all the multiple details of this program was time consuming. Even though the physicians administered the vaccine, the submission of data to the Vaccine Evaluation Center and all the correspondence is entailed continued through the year. However, 5,029 Arkansas School children received the Salk poliomyelitis vaccine which it is hoped will be reflected in a lowered incidence of poliomyelitis in succeeding years.

During the calendar year 1954, 1,351 previously untreated syphilis cases were reported to the Venereal Disease Control Division. In the same period 1,553 individuals were reported to have acquired gonorrhea. This represents a slight reduction in the reporting of both diseases as compared to the previous year. During the past year, the Venereal Disease Control Division stressed two phases of control: (1) The operation of the new Prevention and Control Center which replaced the Hot Springs Treatment Center, and (2) contact interviewing and investigation. Both have been effective as control measures.

The premarital blood testing results for the past year have now indicated a need for broader and more effective testing, including a return to selective mass blood testing.

Because of a reduction in Federal funds, two rather than three mobile X-ray units were operated. 187,257 X-rays were made by the two mobile units together with stationary units located in Fort Smith and Little Rock. 673 tuberculosis suspects were discovered, with 344 definite cases found. The total number of tuberculosis cases reported from all sources was 1,586, which represents a considerable increase over the previous year.

More than 12,000 known cases of tuberculosis were under supervision, more than half of which were in a communicable stage. Although the death rate decreased as the result of the use of new anti-biotics and the more effective use of surgery, Arkansas continued to have the fourth-highest death rate in the Nation. There was no evidence that the prevalence or incidence of the disease was decreased during the past year. The recalcitrant patient continued to present the most pressing obstacle to more effective control of the disease.

The State Health Department has continued its financial and cooperative participation in the all-purpose, outpatient, mental hygiene clinic at the University of Arkansas School of Medicine. The department provided salaries for one psychiatrist, one clinical psychologist, and two clerical workers.

The clinic operated on a full time basis. The total number of admissions for the year was approximately 300. The total number of clinic visits was approximately 1,800. Group therapy was made available to more than 250 patients.

The newly organized Arkansas Mental Health Society and other interested groups are showing keen interest in mental hygiene program planning for the future. Additional diagnostic and treatment clinics as well as adequate follow-up services in this field are badly needed throughout the State.

Diagnostic and consultative community clinical services, in cooperation with the Arkansas Heart Association, have been the chief community service emphasized, in this field, during the year. The Division has continued its financial and cooperative support to the University of Arkansas Heart Clinic. During the year approximately 2,300 patients were admitted for various cardiac services.

Community clinics throughout the State were conducted on the request of local Medical Societies. The attendance through referrals to eight local clinics was 350 adults and children. These clinics resulted in four of the patients being referred to the University of Arkansas School of Medicine for heart surgery. Today they are all leading normal lives.

During 1954, the Division of Hospitals licensed 144 hospitals and 50 nursing homes. Federal funds under the Hill-Burton program were made available and administered by the hospital division for Federal assistance in the construction of seven hospitals. Plans for 1955 include a survey of the diagnostic or treatment centers, the rehabilitation facilities, the chronic disease hospitals, and the nursing homes in the State in order that Federal funds may be received for assistance in the construction of the aforementioned facilities in areas of greatest need in the state.

Recent time studies reveal that Arkansas public health nurses spend more than 50 percent of their time in maternal and child health activities. To help them give more efficient and complete service, the Division of Maternal and Child Health provided medical, nursing, nutrition,

ACH

ACHROMYCIN has proved effective against:

Pharyngitis
Acute Bronchitis
Tonsillitis
Pertussis
Otitis Media
Scarlet Fever
Osteomyelitis
Epidermal Abscesses
Acute Brucellosis
Pancreatic Fibrosis
Typhus Fever
Sinusitis
Gonorrhea
Bacillary Dysentery
Pneumonia with or without Bacteremia
Bronchopulmonary Infection
Acute Pyelonephritis
Chronic Pyelonephritis
Mixed Bacterial Infections
Soft Tissue Infections
Staphylococcal Septicemia
Pneumonoccal Septicemia
Urogenital Tract Infections
Acute Extraintestinal Amebic Infections
Intestinal Amebic Infections
Subacute Bacterial Endocarditis

ROMYCIN*

HYDROCHLORIDE
Tetracycline HCl *Lederle*

A TRULY BROAD-SPECTRUM ANTIBIOTIC

Clinical research has proved ACHROMYCIN to be effective against more than a score of different infections, including those caused by Gram-positive and Gram-negative bacteria, rickettsia, certain viruses and protozoa.

In addition to its true broad-spectrum activity, ACHROMYCIN provides more rapid diffusion than certain other antibiotics, prompt control of infection, and the distinct advantage of being well tolerated by most persons, young and old alike.

ACHROMYCIN, in its many forms, was accepted by the medical profession in an amazingly short time. Each day more and more prescriptions for ACHROMYCIN are being written when a broad-spectrum antibiotic is indicated.

Lederle LEDERLE LABORATORIES DIVISION *AMERICAN Cyanamid COMPANY* Pearl River, New York

*REG. U.S. PAT. OFF.

and hearing and vision consultation and assistance, and supplies, equipment, literature, exhibits, and publications, during the year. Similar service is offered to physicians, hospitals, schools, and parent groups. The staff pediatric consultant filled numerous requests for consultation with local health personnel and for demonstrations and talks related to physical and emotional well-being of children. The specialized consultant nurse advised and assisted local health personnel and hospitals with problems concerning maternal and child health, with emphasis on premature infants and midwife control. Preliminary figures for 1954 indicate that midwives attended approximately 5,500 deliveries, or about 12.9% of the live births in the State. Ten years ago the percentage was 19.5.

Staff hearing and vision consultants trained lay personnel in methods approved by Medical Society committees for screening programs in schools. Schools reported 66,707 children screened for vision defects in 47 counties and 31,670 for hearing in 25 counties. The Division cooperated in sponsoring two state-wide Health Education Workshops, one for white and one for Negro Educators. A conference on school health with State Medical and Dental society representatives was included.

A program of visits with local public health nurses, by junior medical students to homes of maternity patients was inaugurated. These visits offer observation of one phase of public health work in a community and emphasize the relationship of family environment to medical problems. The nutrition service has attempted to support the prenatal instruction and guidance in child feeding provided through public health nurses and the instruction given mothers in hospitals, so that there would be a continuous nutrition education program for the family. Dietary consultation service has been supplied to food service managers in hospitals. Plans for 1955 include joint visits to all well-child conferences by the pediatric and nursing consultants, complete re-writing of three Health Department publications; and continuation and improvement of all present activities.

More supervisory assistance was given to local public health nurses to help them improve their programs. The supervisory staff is composed of six local supervisors who give supervision in 29 counties and 1 city health department and the 5 nurses on the State staff, who act as supervisors in the remaining counties where nurses are employed. In October a well-qualified consultant in tuberculosis was added to the State staff. This will make possible material improvement throughout the State in public health nursing services for tuberculous patients.

Additional help has been given to local public health nurses through workshops in mental health, regular in-service education conferences, and consultation on their special problems.

Public health nursing services in the counties increased in the following areas: expectant mothers, postpartum mothers, premature infants, and crippled children. More infants and preschool children received medical and nursing services in local health department clinics and conferences. Midwives were given more supervision through planned classes taught by public health nurses, with the result that a larger number of midwives than in previous years were influenced to retire from practice.

Nursing consultation was given to 12 hospitals and clinics in the State towards improving nursing care for premature and newborn infants. A workshop on curriculum improvements was offered to the 6 schools of nursing in the state to improve teaching in public health in the basic curriculum.

The total number of nurses employed for public health nursing by the State Department is 103—one-third of the number needed for an adequate State-wide program. During 1954, 16 new nurses were employed, but 11 resignations took place. At the end of 1954, 16 counties were without the services of a public health nurse.

In 1954 the work load of the Bureau of Laboratories remained at about the same level as in the two previous years. Slight increases in the number of tests for syphilis were offset by slight decreases in the number of microscopic and bacteriological examinations. Total number of tests performed was approximately 290,000. The typhoid vaccine required for the immunization program was manufactured by this division.

A definite increase in the procedures carried out for the Bureau of Sanitary Engineering was noted. The number of drinking water samples for bacteriological examination alone increased by 1,200 to 14,813. This is the largest number of such samples ever tested in one year in this state.

The list of private laboratories approved for premarital blood tests has become stabilized at 85. The quality of the serological tests for syphilis being done in these laboratories, as reflected in the results reported on monthly evaluation specimens, has shown steady improvement and can be regarded as very satisfactory.

The National Evaluation of Serologic Tests for Syphilis in State Public Health Laboratories conducted by the U. S. Public Health Service was resumed in 1954, and our own Serological division is taking part.

There was little change in the total number of animal heads showing evidence of rabies, but during the closing months of 1954 a downward trend appeared, which it is hoped will continue.

In 1955 this Laboratory will take part in an evaluation of fungus identification carried out by the U. S. Public Health Service. The Senior bacteriologist recently has received special training in this field and more requests for this type of diagnosis will be welcomed.

In 1955 services in the diagnosis of those diseases of public health significance, checks on the safety of public water and food supplies, and the manufacture of typhoid vaccine for free distribution in this State will be continued.

Sixty-five regular monthly educational meetings and one annual meeting of water works personnel have been participated in by the engineers in the Bureau of Sanitary Engineering. Periodic inspections have been made of most of the 236 municipal and institutional water supplies, 132 municipal sewerage systems, and 94 public swimming pools. Ninety sets of engineering plans and specifications for water and sewerage improvements and new swimming pools have been reviewed and approved by this division. This Bureau has provided engineering service for designing water and sewerage facilities for quite a number of public schools this year.

During the calendar year of 1954 the Division of Food and Drug Control experienced a program greatly varied in nature. Much work was done in the field of drug investigation designed to prevent the illegal sale of dangerous drugs. Other drug investigational work aided in the removal from the marked of several misbranded and potentially dangerous preparations. The rapid growth of the broiler industry in the State of Arkansas made it im-

perative that our inspection program be intensified in many poultry dressing plants. During 1954 our inspection program was extended to cover two additional types of food processing plants—rice mills and cotton seed oil mills. Considerable work was done in inspecting other foodhandling establishments such as canning plants, cafes, markets, sanitary facilities at commercial sorghum mills was stressed, and action was taken to stop the sale of mislabeled imitation sorghum. In the field of environmental health training, members of the Division served as instructors in five foodhandler schools held in various parts of the State. The Division also aided in the training of two new sanitarians during the year. Further educational work included the making of lectures in various colleges, the medical school, and at several group meetings on food sanitation and food and drug regulatory work.

The activities of the Dairy Products Division have been concentrated mostly on quality of the raw product received at the processing plants, physical equipment, and general sanitation.

The purpose of our program is to prevent not merely correct, insanitary conditions. This involves inspecting all processing plants, independents selling dairy products to the various plants, warehouses rented for storing supplies, and even retail outlets.

We plan, with the limited personnel available, to carry on a diversified program covering all phases of the industry.

During the past year The Division of Milk Control made 27 investigations of out-of-state milk suppliers who were selling in Arkansas. Each was given a permit, which they must have before bringing milk into the State. 21 investigations were made of local suppliers selling milk in other states and some 400 of the producers supplying milk to these plants. These suppliers were certified to those states as meeting the minimum requirements of the rules and regulations of the Board of Health and the state laws of Arkansas. Twelve investigations were made of milk plants seeking to secure permits to furnish milk on interstate carriers.

Plans were approved for 5 new pasteurization plants and 327 new dairy barns that were constructed in the State this year. 17 short-course schools were held to inform local inspectors and producers and plant operators of acceptable methods in handling milk and milk products. These schools were attended by more than 500 people. Four new nationally-known milk companies began operation in the State during the past year. More than 400 laboratory examinations were made of processors' milk to determine if the bacterial count, amount of butterfat, etc., met the requirements of the State law. Conferences were held with five state organizations to assist them and inform the personnel so that they might better handle the milk program within their own organization. Every plant, along with the producers for every plant, was inspected by this office at least twice during the last year.

896 master plumbers and 912 journeyman plumbers licensed during 1954. 17 examinations for licenses were given. Of the 103 master plumbers scheduled to take examinations 52 passed, 34 failed, and 17 were absent. Of the 110 journeyman plumbers scheduled, 62 passed, 24 failed, and 24 were absent.

932 inspections of plumbing installations were made by 4 inspectors in 1954, with 256 re-inspections of unsatisfactory work, making a total 1,138 inspections. Of these inspections, 419 were unsatisfactory and 769 were satisfactory, making a percentage of 65% satisfactory and 35% unsatisfactory.

63 cities have adopted the State Plumbing Code. About 40 code reviews have been held over the State. Plans for coming year include continued encouragement to municipalities to adopt the State Plumbing Code and establish local enforcement. An intensified public education program, stepped-up inspection activities.

The Division of Dental Hygiene activities are summarized as follows: the Director spoke before 68 different groups including civic, official, educational and professional groups as well as radio appearances and lectures to colleges. He also participated in 11 conferences, 3 workshops, and 5 examinations of school children. 106 different columns were distributed on a weekly basis to 178 papers—one a Sunday Magazine exclusive on a weekly basis, assisted in preparation of full page story on fluoridation. Distributed 17,911 individual pieces of literature on dental subjects.

At the close of this calendar year, a total of 18 communities fluoridated water supplies, a greater number than any other state in District VII of the public health service. This success would not have been possible except for the splendid cooperation of our Bureau of Sanitary Engineering and the Arkansas State Dental Association. Through the use of a Dental Hygienist supplied by the U.S.P.H.S., we were able to conduct fluoride and nutrition studies which are continuing.

The Society as well as the individual members have given us the most complete and hearty cooperation. A system of 90 coordinators or representatives of the Society, distributed in strategic locations, are available and being used in coordinating our program with both the profession and the educational authorities. Arkansas is the only state in which such a program exists.

Public Health activities are summarized as follows: the Film Library continued its excellent service to the public. The distribution pattern of the films was good and indicated good state-wide coverage. Between July and January, literature distributed entirely through the Division of Health Education amounted to 19,093 pieces. Many divisions distribute their own literature in addition to this.

The activities of the health educator were as follows: prepared reports as requested; edited the Arkansas Health Bulletin (three issues); prepared a supplement to the Film Catalogue; attended several conferences or workshops; and carried on an intensive program on the hazards resulting from incorrect use of fuel oils, especially in the rural areas.

THIRD COUNCILOR DISTRICT PROFESSIONAL RELATIONS COMMITTEE

M. C. JOHN, JR., Chairman

There have been no complaints reported in the THIRD COUNCILOR DISTRICT during the past year. Each committee member representing the respective county societies was contacted and no grievance had been received by them or brought to their attention.

SIXTH DISTRICT PROFESSIONAL COMMITTEE

R. R. KIRKPATRICK, Chairman

This committee has not had a meeting nor have we had any complaints of any kind come to my knowledge. Since we have had no complaints to consider we have not met.

EIGHTH DISTRICT PROFESSIONAL RELATIONS COMMITTEE

HENRY G. HOLLENBERG, Chairman

During the past year our Committee has formally considered a half dozen cases. Each case required a great deal of investigation, study and diplomatic handling. We have found it impossible to satisfy everyone concerned.

Two of these cases involved complaints regarding the treatment of malignant tumors. One concerned the complaint that a certain acceptable form of treatment might have been more effective than an acceptable form which had been utilized. Two cases involved fees which were actually not out of line. The Committee is impressed by the "crackpot" nature of many complaints. In dealing with such people it is impossible to get a common ground understanding.

Our Committee functions smoothly on a local level. There is no contact with the State Committee of which we are an integral part. There is a lack of understanding concerning the routing of cases and actually of the existence of this Committee work by members of our profession. One case originating in this district was handled on the state level. In another case the preliminary work was done by the County Society under the misconception that this Committee work was a County Society function. In both of these cases the matters were nicely handled.

The scope of this Grievance Committee work does not seem to be growing in this community. If this tendency prevails we feel that the volume of work can probably be handled along lines currently in use. However, if the number of cases should increase or if the availability of this Committee should be made known through further advertisement in press or radio, we feel that renewed thought would need to be given to the organization. There are serious legal pitfalls as well as grand opportunities to make no friends and influence people adversely.

TENTH DISTRICT PROFESSIONAL RELATIONS COMMITTEE

During the year of 1954, there were no complaints, filed with the Tenth District Professional Relations Committee. There were no hold over reports from 1953.

THE ARKANSAS STATE CANCER COMMISSION

W. R. BROOKSHER, Secretary

The Arkansas State Cancer Commission, established at the request of the Arkansas Medical Society and the Arkansas Division, American Cancer Society, completed its ninth year of service to indigent cancer patients in Arkansas June 30, 1954. 1,440 patients were hospitalized and/or received domiciliary care. 777 patients were received at the seven permanent tumor clinics in the state. These services have been made available through funds received from the State of Arkansas, the Federal Government, and the Arkansas Division, American Cancer Society.

Patients having cancer, or suspected of having cancer, are referred to the seven permanent tumor clinics by private physicians, the State Cancer Commission, the Arkansas Division, American Cancer Society, by individuals interested and by direct application of the patient for service. Patients not classified as indigent receive routine diagnostic care and are then referred as private patients. Indigent patients, eligible for benefits under the Arkansas program, receive diagnosis and treatment gratuitously from members of the tumor clinic staffs and other physicians. In some instances, roentgen-ray therapy is provided by hospitals cooperating with the tumor clinics without charge.

Funds of the Arkansas State Cancer Commission provide per diem hospitalization and funds of the Arkansas Division, American Cancer Society, provide domiciliary care. There is no provision for the care of terminal cases. No payments are made for the services of the cooperating physicians and grateful acknowledgment is made to them for their unselfish devotion to the care of the indigent cancer patient in Arkansas.

Because of expansion of the program and continued limitation of funds, it has become necessary to require advance approval for hospital admissions of patients eligible to such benefits. Funds are not available as a part-pay plan whereby patients may pay part of the costs of hospitalization. The attending physician certifies that the patient is unable to meet any of the costs of either hospitalization, domiciliary care or of professional service. Acceptance of the patient by physicians and hospitals is evidence that additional payments for care are not expected or to be accepted from the patient.

Attention of members of hospital staffs is called to the new "Minimum Requirements of the American College of Surgeons for Approval of a Cancer Program," applicable to all hospitals who receive cancer patients, and which will become effective December 31st, 1955. All hospitals have received this manual and respective staffs are urged to take proper steps to implement these requirements in Arkansas hospitals.

LIAISON WITH THE NURSING PROFESSION

HOYT CHOATE, Chairman

The Professional Nurses of Arkansas have had an energetic program throughout the year. The annual meeting of the Arkansas League for Nursing was held at the La-Fayette Hotel in Little Rock early in June, 1954. The theme of the meeting was "The Improvement of Patient Care." A panel discussion was conducted by representatives from the League for Nursing, the Arkansas Medical Society and the Arkansas Practical Nurses Association. A large and enthusiastic group of nurses participated in the question forum. From this meeting and it's theme was born the Arkansas Commission for the Improvement of Patient Care. This Commission is composed of four members from each of the following parent organizations. The Arkansas Medical Society, the Arkansas League of Nursing, The Arkansas State Nurses Association and the Arkansas Hospital Association. This Commission meets every two months and discusses problems of patient care and grievances between the departments. From this Commission has come a nurses' Aide Training Program which will prove most valuable in the future.

The Professional and Practical Nurses have developed a most harmonious relationship. Together they proposed a new nurse-practice act which was wisely not presented to the Legislature at this time because all provisions were not readily acceptable by other interested groups.

The Arkansas Nurse's Association, in conjunction with the National Nurse's Organization, has promoted a "nurse-function study" in ten Arkansas hospitals. They have donated $24,000 to this work. The results of this survey are being published now. Dr. Donald D. Stewart of the University of Arkansas at Fayetteville directed and summarized the material. This project will be the basis of some valuable nurse-function application in hospital work in some of the new hospitals due to open soon.

REPORT OF THE EXECUTIVE SECRETARY

MR. PAUL C. SCHAEFER

Continued improvements in office procedures, greater efficiency through better equipment, more office space and lower personnel turnover during 1954 have made it possible for the Executive Secretary to spend more time representing the Arkansas Medical Society to the public. Numerous talks were made to civic clubs, women's groups, county medical societies and business and professional associations. He personally called on Arkansas Senators and Representatives in Washington, to oppose legislation vitally affecting medicine. He testified before Arkansas Legislative Committees and was in attendance at the Arkansas Legislature during its 1955 session. It is believed that acquaintances made among the legislators, and legislative procedures learned, will be of great value to the Society in the future.

At the end of 1954, there were 1,099 dues-paying members of the Arkansas Medical Society; seventy-two physicians held life memberships and sixty-seven were granted affiliate status, totalling 1,238 active members for the year.

American Medical Association membership was just sufficient to qualify us for two delegates to the House of Delegates of the A.M.A. Our records indicate 1,013 members from Arkansas belong also to A.M.A. Of this number, 922 paid dues, 33 held life membership and 58 were granted affiliate status.

The staff of the headquarter's office, under the direction of the officers and Council of the Society, is here to serve its members, and opportunities to do so are welcomed.

The attention of the membership is called to the following amendments to the Constitution, which were given their first reading at the 1954 Annual Session and which may be considered at Hot Springs for final enactment:

AMENDMENT TO THE BY-LAWS OF ARKANSAS MEDICAL SOCIETY

Chapter I. Addition to Section 4:

An annual affiliate membership may be granted interns and residents who have been recommended as such by the individual County Medical Society in which the internship and residency is located. This type of member shall be accorded full privileges, except that he may not vote, and he shall receive the Journal of the Arkansas Medical Society.

Chapter VIII. Section 1:

(a) Delete "Veterans Administration" from the 6th Committee of Public Relations.

(b) Add after "8. Committees on Arrangements," and before the Section a and b of Section 1, 9. "Committee on Veterans Administration Affairs."

THE ANNUAL ESSAY AWARD

Sponsored by the American Congress of Physical Medicine and Rehabilitation

To stimulate interest in the field of physical medicine and rehabilitation, the American Congress of Physical Medicine and Rehabilitation will award annually a prize for an essay on any subject relating to physical medicine and rehabilitation. The contest, while open to anyone, is primarily directed to medical students, internes, residents, graduate students in the pre-clinical sciences and graduate students in physical medicine and rehabilitation.

The Following Rules and Regulations Apply to the Contest

1. Any subject of interest or pertaining to the field of physical medicine and rehabilitation may be submitted.

2. Manuscripts MUST BE in the office of the American Congress of Physical Medicine and Rehabilitation, 30 N. Michigan Ave., Chicago 2, not later than June 1, 1955.

3. Contributions will be accepted from medical students, internes, residents, graduate students in the pre-clinical sciences, and graduate students in physical medicine and rehabilitation.

4. The essay must not have been published previously.

5. The American Congress of Physical Medicine and Rehabilitation shall have the exclusive right to publish the winning essay in its official journal, the ARCHIVES OF PHYSICAL MEDICINE AND REHABILITATION.

6. Manuscripts must not exceed 3000 words (exclusive of headings, references, legends for cuts, tables, etc.), and the number of words should be stated on the title page. An original and one carbon copy of the manuscript must be submitted.

7. The winner shall receive a cash award of $200, a gold medal properly engraved, a certificate of award and an invitation to present the contribution at the 33rd Annual Session of the American Congress of Physical Medicine and Rehabilitation at the Hotel Statler, Detroit, August 28-September 2, 1955.

8. The winner shall be determined by the Annual Awards Committee composed of four members of the American Congress of Physical Medicine and Rehabilitation.

9. All manuscripts will be returned as soon as possible after the name of the winner is announced.

10. The American Congress of Physical Medicine and Rehabilitation reserves the right to make no award if, in the judgment of the Prize Lecture Committee, no contribution is acceptable. The Congress may also award certificates of merit to contributors whose essays may be considered second and third best submitted. Announcement of the winner will be made after the annual meeting.

PROGRAM

SEVENTY-NINTH ANNUAL SESSION
ARKANSAS MEDICAL SOCIETY

ARLINGTON HOTEL — HOT SPRINGS
May 30, 31 and June 1, 1955

ANNOUNCEMENTS

REGISTRATION—

The registration desk will be located on the mezzanine floor of the Arlington Hotel and will be open from noon until 5:00 P.M., Sunday, May 29th, from 9:00 A.M. to 5:00 P.M., Monday and Tuesday, and from 9:00 A.M. to noon on Wednesday.

Delegates are requested to register as early as possible, presenting credentials in proper form at the time of registration. Members and visitors are required to register, as admission to all sessions will be by badge. Bring your 1955 membership card to facilitate registration. Members of the American Medical Association from other states may register as guests.

Special telephone service will be maintained at the registration desk—phone number 4951.

MEETINGS OF THE COUNCIL

The Council of the Arkansas Medical Society, including past presidents, will meet as follows:

Sunday Night, May 29th	8:00 P.M. in Cafe 2, Arlington Hotel
Monday, May 30th	7:00 A.M. in Cafe 2, Arlington Hotel
Tuesday, May 31st	12:15 P.M. in Cafe 2, Arlington Hotel
Wednesday, June 1	12:15 P.M. in Cafe 2, Arlington Hotel

FIFTY-YEAR CLUB BREAKFAST—

A breakfast for members of the Fifty-Year Club of the Arkansas Medical Society will be held in Cafe 2, Arlington Hotel at 7:30 A.M., Tuesday Morning, May 31st. For reservations, members are requested to contact Dr. J. H. McCurry, Fifty-Year Club Secretary at the Arlington Hotel prior to 6:00 P.M., Monday, May 30th.

PAST-PRESIDENTS' BREAKFAST—

The Past-Presidents' Breakfast will be held in Cafe 2, Arlington Hotel, at 7:30 A.M. on Wednesday, June 1st.

All members who were present at the reorganization meeting of the Arkansas Medical Society in 1903 are urged to attend a luncheon at 12:15 P.M., Monday, May 30th, (in a suite to be announced) at the Arlington Hotel.

FISHING, SWIMMING, BOATING—

Garland County Medical Society advises members and guests to bring equipment and attire for fishing, swimming, and boating, which will be available at Lake Hamilton.

GOLF TOURNAMENT—

Members are urged to bring golf clubs and enter the annual tournament. Both Hot Springs courses will be open to play. Physicians should register for the tournament on the mezzanine floor of the hotel.

FIRST GENERAL SESSION

9:00 A.M., Monday, May 30th

Main Ballroom, Arlington Hotel

Presiding: W. R. Brooksher, President, Fort Smith.

9:00 A.M.—Call to Order.
Invocation.
President's Address—W. R. Brooksher, Fort Smith.

SCIENTIFIC SESSION—

Presiding: Thomas P. Foltz, Fort Smith.

9:25 A.M.—"Regional Ileitis"—Burril B. Crohn, New York.

9:50 A.M.—"Headache Mechanisms"—Stewart Wolfe, University of Oklahoma Medical School, Oklahoma City.

10:15 A.M.—INTERMISSION.
(Time to visit Commercial Exhibits.)

10:40 A.M.—"X-Ray Signs of Small Bowel Dysfunction"—Fred J. Hodges, University of Michigan, Ann Arbor, Michigan.

11:05 A.M.—"Gynecological Surgery in the Geriatric Patient"—Joseph H. Pratt, Mayo Clinic, Rochester, Minnesota.

11:35 A.M.—"The General Practitioner and the Sterility Problem"—James H. Ferguson, Tulane University, New Orleans, Louisiana.

12:15 to 1:30 P.M.—SPECIAL SECTIONS LUNCHEONS.

INTERNAL MEDICINE—

Fountain Room, Arlington Hotel. Presiding: Albert Hammon, Harrison.

OBSTETRICS AND GYNECOLOGY—

Banquet Room, Arlington Hotel. Presiding: C. R. Simmons, Pine Bluff.

MONDAY AFTERNOON—

1:30 to 4:00 P.M.—SYMPOSIA.

INTERNAL MEDICINE—

Fountain Room. Presiding: Wm. L. Davis, Searcy.

"A Critical Appraisal of Therapy in Duodenal Ulcer"—Stewart Wolf, Oklahoma City.

"Gastro-enterologic X-Ray Problems"—Fred J. Hodges, Ann Arbor, Michigan.

"Peptic Ulcer and Its Complications, Dealing Particularly with the Differentiation of Benign From Malignant Gastric Ulcer, Hemorrhage, Perforation, and Pyloric Obstruction"—Burrill B. Crohn, New York.

"....."—O. T. Bailey, Indianapolis, Indiana.

OBSTETRICS AND GYNECOLOGY—

Banquet Room. Presiding: J. F. Kelsey, Fort Smith.

"Indications, Contra-Indications and Technic in Vaginal Hysterectomies"—Joseph H. Pratt, Rochester, Minnesota.

"Management of Pregnancy in Essential Hypertension"—James H. Ferguson, New Orleans, Louisiana.

HOUSE OF DELEGATES

Monday Afternoon, May 30th, 4:00 P.M.

Main Ballroom, Arlington Hotel

Calling Meeting to Order.

Roll Call of Delegates.

Report of Credentials Committee.

Introduction of Fraternal Delegates.

Adoption of minutes of the Seventy-Eighth Annual Session, published in the June, 1954, issue of the Journal of the Arkansas Medical Society.

Reports of Committees (as published in the March, 1955, issue of the Journal of the Arkansas Medical Society).

Reports may be amended by Committee Chairmen. All reports will be referred to the Reference Committees:

(1) C. C. Long, Ozark, Chairman; Carl Wilson, Fort Smith; Lawrence H. Siegel, Fayetteville.

(2) H. W. Thomas, Dermott, Chairman; Jack W. Kennedy, Arkadelphia; Swan B. Moss, McGehee.

CANCER CONTROL—C. A. Archer, Jr., Chairman.

MEDICAL LEGISLATION—Joe Shuffield, Chairman.

PUBLIC HEALTH—Ben N. Saltzman, Chairman.

MATERNAL AND CHILD WELFARE—Roger Bost, Chairman.

INDUSTRIAL HEALTH—H. E. Mobley, Chairman.

TUBERCULOSIS—Jerome S. Levy, Chairman.

MENTAL HEALTH—E. H. Crawfis, Chairman.

LIAISON WITH STATE BOARD OF HEALTH—T. N. Rodman, Chairman.

POLIO ADVISORY COMMITTEE—E. H. Crawley, Chairman.

MEDICAL EDUCATION—H. W. Thomas, Chairman.

POSTGRADUATE EDUCATION—James M. Kolb, Chairman.

HOSPITALS—A. S. Koenig, Chairman.

LIAISON WITH BLUE CROSS-BLUE SHIELD—Sam Jameson, Chairman.

PUBLIC RELATIONS—Dale Alford, Chairman.

LIAISON WITH AUXILIARY—Charles Henry, Chairman.

HEALTH AND MEDICAL RESOURCES FOR CIVIL DEFENSE—Joe Norton, Chairman.

LIAISON WITH NURSING PROFESSION—Hoyt Choate, Chairman.

VETERANS AFFAIRS—Elvin Shuffield, Chairman.

AMERICAN MEDICAL EDUCATION FOUNDATION—W. R. Brooksher, Chairman.

STATE ADVISORY COMMITTEE TO SELECTIVE SERVICE—Gerald Teasley, Chairman.

PROFESSIONAL RELATIONS—O. J. T. Johnston, Chairman.

REPORT OF THE EXECUTIVE SECRETARY—Mr. Paul C. Schaefer.

ANNUAL SESSION—H. King Wade, Jr., Chairman.

SCIENTIFIC PROGRAM—Alfred Kahn, Jr., Chairman.

REGISTRATION—J. W. Leatherman, Chairman.

ENTERTAINMENT—John W. Dodson, Jr., Chairman.

GOLF—Gaston A. Hebert, Chairman.

TRANSPORTATION—Fred Reed, Chairman.

COMMERCIAL EXHIBITS—Charles P. Harris, Chairman.

NEW BUSINESS—

ELECTION TO FILL VACANCIES ON THE ARKANSAS STATE BOARD OF HEALTH. Vacancies occur in the following Congressional Districts, the counties of which are listed below. All members registered from the following counties are eligible to attend meetings and vote for nominees.

THIRD DISTRICT—Will meet at 1:30 P.M., Monday, May 30, in the Library, Hotel Arlington.

SIXTH DISTRICT—Will meet at 2:00 P.M., Monday, May 30, in the Library, Hotel Arlington.

THIRD DISTRICT—Baxter, Benton, Boone, Carroll, Crawford, Franklin, Johnson, Logan, Madison, Marion, Newton, Scott, Searcy, Sebastian, Van Buren, Washington counties. Present member: D. W. Goldstein, Fort Smith, eligible for reappointment.

SIXTH DISTRICT—Arkansas, Chicot, Cleveland, Dallas, Desha, Drew, Garland, Grant, Hot Spring, Jefferson, Lincoln, Lonoke, Saline counties. Present member: J. P. Price, Monticello, eligible for reappointment.

SELECTION OF NOMINATING COMMITTEE

MONDAY EVENING—

Hosts—The Garland County Medical Society. Dancing, Motor Boating, Fishing, Swimming and Refreshments. Special buses will leave the Arlington beginning at 6:00 P.M.

SECOND GENERAL SESSION

Tuesday Morning, May 31, 9:00 A.M.

Ballroom, Arlington Hotel

(The E.E.N.T. group will meet all day, including luncheon, in the Banquet Room.)

Presiding: Eldon Fairley, Wilson.

9:00 A.M.—"Surgical Treatment of Pancreatitis"—James T. Priestley, Mayo Clinic, Rochester, Minnesota.

9:25 A.M.—"Cardiac Arrest"—Henry Swan, University of Colorado Medical School Denver, Colorado.

9:50 A.M.—"The Non-Operative Management of the Problem of the Backache"—Carroll Larson, University of Iowa Medical School, Iowa City, Iowa.

10:15 A.M.—INTERMISSION.
(Time to visit Commercial Exhibits.)

10:40 A.M.—"Points Often Overlooked in Examining Children"—E. H. Watson, University of Michigan, Ann Arbor, Michigan.

11:05 A.M.—"Recent Advances in the Basic Sciences"—O. T. Bailey, University of Indiana, Indianapolis, Indiana.

11:30 A.M.—MEMORIAL SERVICE. Main Ballroom, Arlington Hotel.

Presiding: W. R. Brooksher, Fort Smith, President.

Invocation.

Music.

Memorial Address.

In Memoriam (Reading of the names of the departed).

Music.

Benediction.

10:00 A.M.—SPECIAL SECTIONS PROGRAMS AND LUNCHEONS.

EYE, EAR, NOSE AND THROAT SECTION—

Banquet Room—Tuesday, May 31st, 10:00 A.M.

Chairman's Address—"Some Facts About the Blind in Arkansas"—K. W. Cosgrove, Little Rock.

"Glaucoma"—Peter C. Kronfeld, Chicago.

LUNCHEON AND ROUND TABLE DISCUSSION—

"Serious Otitis Media"—Charles Watkins, Little Rock.

"Place of Rhinoplasty in Ophthalmology"—Samuel Foman, New York City.

TUESDAY AFTERNOON—

12:15 P.M.—LUNCHEONS.

PEDIATRIC SECTION—
(Suite to be announced.)

Presiding: Dina Bayer, Texarkana.

SURGERY SECTION—

Fountain Room.

Presiding: J. B. Holder, Monticello.

1:30 to 4:00 P.M.—SYMPOSIA.

PEDIATRIC SECTION—
(Suite to be announced.)

Presiding: James T. Rhyne, Pine Bluff.
William F. Barron, Harrison.
Roger Bost, Fort Smith.

SURGERY SECTION—

Fountain Room.

Presiding: H. W. Thomas, Dermott.

"Carcinoma of the Stomach"—James T. Priestley, Mayo Clinic, Rochester, Minnesota.
Henry Swan, Denver, Colorado.

"Treatment of Acute Fracture of the Neck of the Femur"—Carroll Larson, Iowa City, Iowa.
O. T. Bailey, Indianapolis, Indiana.

TUESDAY EVENING—

7:00 to 12:00 P.M.—ANNUAL DINNER AND DANCE.

Main Dining Room, Hotel Arlington.

THIRD GENERAL SESSION

Wednesday Morning, June 1st

Main Ballroom, Hotel Arlington

WHAT'S NEW SYMPOSIUM—

Presiding: Lewis Tilley, Arkadelphia.

9:00 A.M.—"Surgery"—David Yocum, El Dorado.

9:25 A.M.—"Neurology"—William Jordan, Little Rock.

9:50 A.M.—"Obstetrics-Gynecology"—W. D. Thornton, Texarkana.

10:15 A.M.—INTERMISSION.
(Time to visit Commercial Exhibits.)

10:40 A.M.—"Pediatrics"—Joseph L. Rosenzweig, Hot Springs.

11:05 A.M.—"Radiology"—Joseph Norton, Little Rock.

11:35 A.M.—"Clinical Pathology"—A. S. Koenig, Fort Smith.

WEDNESDAY AFTERNOON—

1:30 P.M. —FINAL SESSION—HOUSE OF DELEGATES.
Main Ballroom, Arlington Hotel.

Order of Business.

Roll Call.

Report of Nominating Committee.

Election of Officers—
- President-Elect
- First Vice-President
- Second Vice-President
- Third Vice-President
- Treasurer
- Secretary
- Speaker of House of Delegates
- Councilors from First, Third, Fifth, Seventh and Ninth Councilor Districts

Vice Councilors from First, Third, Fifth, Seventh and Ninth Councilor Districts

Report of Reference Committees.

Report of Committees.

New Business.

Adjournment.

FINAL GENERAL SESSION

Wednesday Afternoon, June 1st
(Following Adjournment of the House of Delegates)

Presiding: W. R. Brooksher, Fort Smith.

Swearing In of New President.

Presentation of the President-Elect.

New Business.

Selection of the Time and Place of Next Meeting.

Adjournment.

COUNCIL MEETING—

The new Council will convene for a brief reorganizational meeting immediately following adjournment.

PROGRAM

THIRTY-FIRST ANNUAL SESSION

May 30, 31 and June 1, 1955

WOMAN'S AUXILIARY

TO THE ARKANSAS MEDICAL SOCIETY

HOT SPRINGS, ARKANSAS — ARLINGTON HOTEL

MONDAY, MAY 30

9:00 A.M.—Registration.

9:15 A.M.—Pre-Convention Executive Board Meeting.

10:00 A.M.—Opening General Session for entire membership—Mrs. C. W. Parkerson, President, Woman's Auxiliary to the Garland County Medical Society.

Invocation—Mrs. K. W. Cosgrove, Chaplain.

Address of Welcome.

Introduction of State President—Mrs. Hoyt Choate.

Response to Welcome.

Introduction of Guests.

Reports of Officers and Committee Chairmen.

Recommendations from Executive Board read and voted on.

Reports of Convention Committees.

12:00 Noon—Doctor's Day Luncheon, honoring Mrs. Louis Hundley, President Women's Auxiliary to the Southern Medical Association, and husbands of Arkansas Auxiliary Members.

Invocation—Mrs. K. W. Cosgrove, Chaplain.

Introduction of Guests.

Doctor's Day Poem—Mrs. George Fletcher, Poet Laureate.

Speaker—Mrs. Louis Hundley.

TUESDAY, MAY 31

8:00 A.M.—Past Presidents' Breakfast.

9:30 A.M.—Second General Session for entire membership.

Presiding—Mrs. Hoyt Choate.

Invocation—Mrs. K. W. Cosgrove, Chaplain.

Minutes of First General Session—Mrs. T. D. Brown, Secretary.

Reports of County Auxiliary Presidents.

Reports of Nominating Committee and election of officers for 1955-56.

Installation of Officers.

11:30 A.M.—Joint Memorial Session with Arkansas Medical Society.

1:30 P.M. —Luncheon honoring Mrs. George Turner, President, Woman's Auxiliary to the American Medical Association.

Presiding—Mrs. C. W. Parkerson, President Garland County Auxiliary.

Invocation—Mrs. K. W. Cosgrove, Chaplain.

Introduction of Guests.

Introduction of Past Presidents.

Introduction of New Officers and Committee Chairmen.

Introduction of Speaker by Mrs. Mason G. Lawson.

Address—Mrs. George Turner.

Reports of Resolutions, Registration and Credentials Committees.

Announcements.

3:00 P.M. —Post Convention Board Meeting immediately following luncheon.

7:00 P.M. —Banquet and Dance—Arlington Hotel.

★ Editorial ★

The Council of the Arkansas Medical Society faces a knotty problem in the recently revised version of the Code of Ethics, and the application of one or two of its sections.

There have been two or three requests come to the Council for the interpretation of the section on the maintenance of a drug store or pharmacy in the physician's clinic or office, and of his being a partner or receiving remuneration from a retail drug establishment to which any palpable percentage of his prescriptions is sent.

Recent action in clearing the board of similar controversy, has come in several ways. A number of Little Rock physicians have sold their stock in and severed their financial connection with a few of their retail drug outlets. The problem is more complex in an office where a country physician has to do considerable dispensing. Surely there is an ethical answer to all facets of drug sales and drug dispensing, in whatever situation the physician practices. The solution will require study and perhaps time, but whatever the answer, the individual physician has but one choice—to conform to that code which elevates and makes above suspicion, any act of his or a fellow practitioner.

The **Journal** calls attention to the enormous amount of footwork (and handwork and headwork) that is being done for our Society and our State by some dozen physicians of the Pulaski County Medical Society who live in Little Rock. During every session of the Legislature there are contacts to be made, committees to meet, on many medical phases; and even sick legislators to be attended. Members who live outside Little Rock can well be reminded that we owe these physicians considerable thanks for their time, interest, and effort to advise and build, for better health of every citizen of our state. The **Journal** salutes, without naming, these unselfish workers.

LETTERS TO THE EDITOR

Dear Editor:

I like your "Fall Medical Education Week" idea very much. How about arranging several post-graduate meetings in one week, together, or successively. Would allow speaker exchange and aid program and attendance. And could end all with the Fall Interim House of Delegates meeting which was popular in 1954. How about it!

Joe Norton.

Dear Editor:

I should like this information to get into the Arkansas Medical Journal for the information of the doctors and agencies in communities throughout Arkansas who would like assistance in the field of child health.

A month or so back I was elected by the pediatricians, who belong to the Academy of Pediatrics in Arkansas, as the State Chairman of the Academy of Pediatrics for the next two years. As you know there has been much progress in the field of pediatrics in Arkansas in the last ten years and it has been most gratifying to me for I have been in practice here for just about that period and have seen it take place.

One of my first duties as State Chairman was to appoint State Committees who would work with the National Committees of the same category. These Committee Chairmen will undoubtedly be sent from the national level a great deal of information which can be used by medical or lay organizations in an educational way. This is one reason why I should like to have all the doctors know who the chairmen and committee members are. In other words, we would all like to render whatever service we can, to assist in improving the health and welfare of the children in this state.

All members have indicated their willingness to serve as members of the following committees:

ACCIDENT PREVENTION—
J. Schuler McKinney, Chairman, El Dorado
James O. Cooper, El Dorado

SCHOOL HEALTH—
John Allen Harrel, Jr., Chairman, Little Rock
Johan W. Eliot, North Little Rock

FETUS AND NEWBORN—
Eugene H. Crawley, Chairman, Little Rock
Johan W. Eliot, North Little Rock

RHEUMATIC FEVER AND CARDIAC DISEASES—
Barney P. Briggs, Chairman, Little Rock
Katharine Dodd, Arkansas School of Medicine, Little Rock

GEOGRAPHICAL DISTRIBUTION OF PEDIATRICIANS—
Joseph Leon Rosenzweig, Chairman, Hot Springs
Sam Phillips, Little Rock
Archibald A. Little, Texarkana

MENTALLY AND PHYSICALLY HANDICAPPED—
Robert L. Henry, Chairman, Little Rock
Edwin C. McMullen, Pine Bluff

If any of us can be of service to the Arkansas Medical Society in the field of child health, please feel free to call on us.

Vida H. Gordon,
State Chairman.

PRESIDENT BROOKSHER HONORED BY SEBASTIAN COUNTY MEDICAL SOCIETY

W. R. Brooksher, President of the Arkansas Medical Society, was honored at the 81st Annual Banquet of the Sebastian County Medical Society held at the Goldman Hotel in Fort Smith on Tuesday, January 18th.

The President of the Society, L. A. Whittaker, spoke of Brooksher's accomplishments in medicine and medical organization on a local, state, and national scale during the past twenty years.

D. W. Goldstein reviewed Brooksher's many accomplishments and, on behalf of the County Society, presented him with a leather briefcase.

Isadore Meschan of the University of Arkansas Medical School, the scientific speaker, described the assistance of Radiology Department of the University had received from Brooksher and the many advancements in the program which he had made possible.

The meeting was one of the largest ever held by the Sebastian County Society, with approximately seventy-five doctors from Northwest Arkansas, neighboring Oklahoma Communities, and the Army Hospital at Camp Chaffee attending.

DID YOU KNOW

In the "average" copy of the A.M.A. Journal you can find:

—Abstracts of all current medical literature.
—Reviews (and procurement addresses) of new medical films.
—Letters to the Editor (and replies).
—Special articles on legal medicine (currently on Income Tax).
—Reports on activities of various councils.
—Foreign letters (medical news, reports, and correspondence).
—Announcements of medical meetings (state, national and foreign).
—Announcements of Boards and Licensure.
—Report on "medical" items in the popular magazines, and what is appearing on TV and radio stations.
—Medical and organizational news.
—Last and not least, the original articles.

A character, quite a character, we'd say, in Congress, Representative Tablocki, from Wisconsin, has introduced (H.R. 1865) a bill to permit the cost of wigs as medical care deductions! Couldn't he include the lady's hats, too? We refrain from further comment as this **Journal** has to go through the U. S. mails.

LETTERS TO OUR SOLONS

Dear Senator McLellan:

We are grateful to you for your firm stand in a previous Congress for the adoption of the Bricker Amendment. We understand it has been presented again and are confident you will once more give it your support.

Physicians are interested in the "Bricker" Amendment because it prevents a small group of men, as little as four or five, from accepting a Treaty which would nullify our own laws governing the regulation of the practice of Medicine, and destroy this safeguard of the health of our people. We thank you for your previous support of the Amendment and ask you to use your influence for its passage this year.

SENECA ON THE PHYSICIAN'S FEE

You imagine that you owe the physician and teacher no more than his fee: but we love and honor both very highly. There are things that must be valued much higher than the sum of money that buys them. You buy from your physician something of inestimable value: life and health. From your teacher you buy knowledge and noble mental culture.

These 2 professions are therefore paid for the trouble they take, and not for particular matters or cases. They have to put aside and neglect their own affairs in order to devote themselves to us.

Why do I consider that the payment of their fees does not absolve me from further debt? Both of them become my friends, and we do not value them because of their commercialized art, but because of their benevolent friendship. The physician's heart beats faster because of me and not because of personal fame in his art. It was not enough that he prescribed and even brought the necessary remedies to me in person. He sat anxiously by my bedside and came at once when any serious symptoms appeared. He did not refuse any service, even the most filthy and loathsome, and he listened to my sighs and complaints with true compassion.

GOITRE PROGRAM

The 1955 meeting of the American Goitre Association will be held in the Skirvin Hotel, Oklahoma City, Oklahoma, April 28, 29 and 30, 1955.

The program for the three-day meeting will consist of papers and discussions dealing with the physiology and diseases of the thyroid gland.

RESOLUTION

Washington County Medical Society

WHEREAS: Richard White Miller, an outstanding member of our profession, has been called by the Silent Reaper to his Eternal Reward; and,

WHEREAS: we feel, with his family, the loss of a loyal, capable, and devoted professional laborer; and,

WHEREAS: his generous offices to rich and poor alike will forever be a monument to his memory in our community; and,

WHEREAS: we, who were his professional brethren, wish to pay a fitting tribute of appreciation of his friendship and high esteem in which we held him; **THEREFORE,**

BE IT RESOLVED: That these expressions be read before our Washington County Medical Society in meeting this day, February 1, 1955, and adopted in honor of the memory of Dr. Miller; and,

BE IT FURTHER RESOLVED: that it be recorded that we feel keenly that his untimely death has deprived us of an outstanding friend and colleague; and,

BE IT FURTHER RESOLVED: that this expression be spread on the records of the Washington County Medical Society, and that copies be furnished his family, and be published further in the Journal of the Arkansas Medical Society, of which he was a loyal member.

Max McAllister, President.
Stanley Applegate, Secretary.

1 February 55.

Resolutions Committee:

G. H. Butler,
C. S. Applegate,
Fount Richardson.

PHYSICIAN PILOTS

Some time ago several physicians simultaneously conceived the idea of forming a national society of flying physicians. Initial action was started by Mr. Mark E. DeGroff of Tulsa, Oklahoma, medical equipment manufacturer, who offered to act as a central office until preliminary arrangements could be made. A notice in the A.O.P.A. Newsletter brought forth over one hundred interested inquiries. About twenty-eight physician pilots attended the American College of Surgeons Meeting in Atlantic City and twenty-four attended the AMA session in Miami. It was felt that enough interest was shown to warrant an attempt to organize.

It was decided that the purpose of this society should be scientific, educational, and social.

The immediate objectives are: compilation of a complete list of physician pilots; appointment of temporary local area chairmen; the collection of ideas and suggestions; and encourage physicians to fly in to the AMA Meeting at Atlantic City, June 6-10, 1955.

A scientific and social program can be arranged at Atlantic City if enough interest is shown.

Will physician pilots who are interested please send their names, plane flown and landing field to the local chairman of their area, or, if not known, to H. D. Vickers, M.D., 25 Jackson Street, Little Falls, New York, temporary chairman.

AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY

ROBERT L. FAULKNER, Secretary
2105 Adelbert Road, Cleveland 6, Ohio

The next scheduled Examinations (Part II) oral and clinical for all candidates will be conducted at the Edgewater Beach Hotel, Chicago, Illinois, by the entire Board from May 12, through May 20, 1955. Formal notice of the exact time of each candidate's examination will be sent him in advance of the examination dates.

It is drawn to the attention of candidates who participated in the Part I examinations that case abstracts must be in this office not later than February 28 if they have not been submitted at the time of the Written Examination.

The Department of Otolaryngology, University of Illinois College of Medicine, announces its Annual Assembly in Otolaryngology from September 19 through October 1, 1955. This Assembly will consist of two parts.

Part I. September 19 through September 24, 1955, will be devoted to surgical anatomy of the head and neck, fundamental principles of neck surgery and histopathology of the ear, nose and throat.

Part II. September 26 through October 1, 1955, will be devoted entirely to lectures and panel discussion of advancements in otolaryngology.

Registration is optional for one or both weeks.

TUBERCULOSIS ABSTRACTS

A Review for Physicians

ISSUED MONTHLY BY THE NATIONAL TUBERCULOSIS ASSOCIATION

CHANGING CONCEPTS IN THE TREATMENT OF TUBERCULOSIS

By GUSTAF A. HEDBERG, M.D.

The Medical Clinics of North America, July, 1954

Before 1947 the treatment of pulmonary tuberculosis, based on rest and support to the patient, was well standardized. In institutions emphasis was placed on strict rest in bed and actual physical immobilization until the lesion had shown maximal improvement and signs of stabilizing. Usually the patient had reached an exercise level of four or more hours before discharge.

In addition to the basic treatment of rest, collapse measures were directed toward the pulmonary disease. Pneumothorax was the most popular procedure, though serious complications such as effusion and empyema sometimes followed. Later there was a trend toward "primary thoracoplasties" wherein permanent collapse was induced by rib resection. Pneumoperitoneum became popular because it was considered harmless and tended to keep the patient in the sanatorium. There was always debate as to the value of phrenic-nerve interruptions. Resections for pulmonary tuberculosis was rare because of the operative danger as well as the danger of spread to the opposite lung.

Since the advent of antimicrobial drugs and the coincidental improvement in anesthesia and pulmonary surgery, tuberculosis therapy has been in continuous change. In 1947 when streptomycin became available the usual dose was 0.5 gram of the antibiotic given every six hours. Under this treatment there were frequent toxic complications, mainly vestibular damage and deafness. It was soon found that streptomycin and dihydrostreptomycin were not bactericidal agents but bacteriostatic. In many patients the surviving tubercle bacilli became resistant to the drug. As a result there was a tendency to introduce thoracoplasty or resection very early in the treatment. Reactivation and spread to other parts of the body were common. Many forgot that tuberculosis is a systemic disease that cannot be controlled by the excision or collapse of diseased parts alone. In 1949 para-aminosalicylic acid (PAS) became available. Streptomycin and PAS combined not only had increased therapeutic effect but tended to delay the emergence of resistant strains of tubercle bacilli.

Long-term effective chemotherapy made it possible to treat patients until maximal resolution had occurred, with resection of residual cavitary and, at times, other infected areas. The number of treatment failures as a result of earlier therapy was considerable. Some of these were salvaged when, in 1951, viomycin and, in 1952, isoniazid became available.

The treatment of tuberculosis has not yet stabilized except possibly in regard to the emphasis of long-term chemotherapy. Indications for resection are becoming more conservative.

Collapse therapy has been almost abandoned in the Nopeming Sanatorium (Minnesota). During the past two years the principle of strict rest in bed has also been abandoned except for toxic patients and those under orthopedic treatment. All are allowed a moderate amount of exercise including full bathroom privileges. The disability from physical immobilization has been reduced but it is more difficult to convince the patient of the necessity for sanatorium treatment. Much more time must be spent in the individual education of the patient regarding the problems of his disease as it relates to himself and to his family and community. With chemotherapy, however, it has been possible to shorten the hospital stay for the intelligent and cooperative patient by a program of postsanatorium outpatient treatment with drugs, given under the supervision of the patient's private physician. The patient returns to the sanatorium periodically for intensive laboratory studies including the culture of gastric specimens. Three months after the end of treatment the patient is again hospitalized for such studies.

The factors taken into consideration in surgical treatment are the presence of residual cavitation and localized extensive nodular disease. Body section radiography is of great value. Operation is delayed until the patient is not excreting tuber-

cle bacilli. If resection is performed the patient is kept on modified exercise of approximately two months, after which exercise is increased gradually. After discharge the patient continues his chemotherapy for a year or more depending upon residual known disease. This institution has become more conservative in recommending surgical treatment, since many resected specimens fail to demonstrate activity of the tuberculosis. Since 1951 only one patient in Nopeming Sanatorium who has taken a minimum of 100 grams of streptomycin with PAS and who has undergone resection has shown evidence of reactivation. Reactivation has occurred in a few patients treated by medical means alone.

It is impossible to evaluate the results of treatment at this time although the reactivation rate after discharge has definitely decreased. Previous to the advent of chemotherapy the reactivation rate among patients discharged as well or improved was approximately 33 per cent over a five-year period.

One might ask why sanatorium care is necessary with present definitive treatment. Why not start a patient on antimicrobial therapy and hospitalize him only for periodic intensive study and during surgical treatment? There are two main reasons for hospitalization during the active period of a person's tuberculosis.

First, patients with active tuberculosis are an actual or potential public health menace, even with intensive drug treatment. Second, it has not been proved that drugs alone "cure" tuberculosis; rest and support promote the patient's innate ability to heal his disease. Further, all the drugs in use have toxic potentialities and some are difficult to take. Toxic manifestations aside from deafness and vertigo are often asymptomatic, requiring repeated laboratory studies. The patient must be taught the importance of taking the prescribed doses of the drugs. Until a "miracle drug" becomes available which is capable of killing the tubercle bacilli quickly, hospitalization during the active stage is necessary.

Two age groups have increased in the sanatorium population—the very young and the very old. The proportion of men more than 60 years of age is steadily increasing. In this group long-term chemotherapy and hospitalization during the entire period of treatment have shown encouraging results. Many continue as chronic active cases, certainly a dangerous group in any community.

The very young are best handled in a hospital. Active primary tuberculosis responds to antimicrobial therapy with rapid conversion of the bacteriologic findings but slow improvement in the pulmonary and glandular lesions.

The present treatment of tuberculosis has far from stabilized and many questions plague the physician. Is there too much dependence on the examination of surgical specimens? Have the earlier procedures been dropped too quickly? Should pneumothorax be reconsidered in conjunction with drug therapy rather than resection?

Meantime the problem of tuberculosis remains that of tthe community and of the individual. More thorough search for the unknown cases must be instituted. Persons with apparently inactive tuberculosis must be checked periodically and all persons with positive tuberculin reactions should be followed by periodic roentgenograms in order to find the disease in its earliest stages.

Obituary

RICHARD WHITE MILLER, 48, Fayetteville, died suddenly January 18.

A native of Fayetteville, and a son of the late Dr. Otey Miller and Mrs. Miller, he was educated at the University of Arkansas and took his medical degree from the University of Tennessee Medical Department in 1934. He came to Fayetteville and opened offices in 1936 which he continued to fill except for 3 years military service, 1942-1944.

Dr. Miller was a member of the American Medical Association; a Past-President of the Washington County Medical Society, and a member of the Arkansas Medical Society. He was active in the social affairs of his community and a Rotarian.

He was buried from the family house in which he lived most of his life. Interment was in Evergreen Cemetery.

ELISHA J. HIGHFILL, 82, widely known Benton county retired physician, died January 21 at the home of his son, Fred, at Highfill, Ark., following a long illness. Funeral services were held at the Cave Springs Baptist Church Sunday afternoon with burial in the Highfill cemetery.

A lifetime resident of Benton County, Dr. Highfill was the son of the late H. Highfill for whom the town, Highfill, was named. He graduated from Barnes Medical School, in St. Louis, and began his medical career which lasted for 50 years before he retired. He was a member of the Baptist Church.

Survivors include his son, one daughter, a foster son, one brother, three sisters, four grandchildren, and two great-grand children.

Personal and News Items

Paul Mahoney of Little Rock attended the American Otorhinologic Society for Plastic Surgery Seminar in Plastic Surgery of the Head and Neck January 20th through 28th in Miami Beach, Florida.

He is a member of the Board of Directors and was Chairman of the Tuesday Session.

F. Walter Carruthers, Little Rock, a member of the Instructional Course Faculty of the American Academy of Orthopaedic Surgeons, gave a lecture on "Treatment of Fractures of the Pelvic Bones" at Los Angeles during its annual meeting in February.

Following the meeting he visited the Shrine Crippled Children's Hospital in Honolulu, T. H.

E. J. Byrd, Camden, is serving currently in the Arkansas Senate. He is one of our Senior Senators.

Ellery C. Gay, Little Rock, is president-elect of the Pulaski County Medical Society for 1955. Ed F. Gray, president, was installed in January. Alfred Kahn, Jr., is recording secretary, and R. M. Blakely, recording-treasurer.

Wayne P. Jones has moved his offices from Batesville to Marshall and has opened a clinic there.

J. F. Gulledge, 90-year-old pioneer physician of Benton County, has been honored recently by the staff of the Memorial Hospital of Siloam Springs and made an honorary member of the Staff.

Louis K. Hundley, Pine Bluff, addressed the District Rotary Meeting at Clarksville during January on "Objectives of Rotary."

The 1955 Directory of Licentiates of the Arkansas State Medical Board will be a month late, due to the reorganization of the board authorized by the recent legislature. Secretary Joe Verser advises that the directory will be printed in April.

Charles William Donaldson, Green Forest, and for 82 years a native son of Carroll County, was honored in the January 27 issue of the Berryville "Star Progress." The story recounted, briefly, the career of the doctor who has maintained an office for 54 active years.

W. J. Weaver, Hampton, has moved to Eudora, and opened a clinic there.

David Dawson has moved to Newport and has joined the staff of Harris Hospital.

George Peeples, formerly of Mount Vernon, Texas, returned to his native state and opened offices in Gurdon on February 7.

Participants in the 7th Annual Institute in Psychiatry and Neurology held February 24-25 in Little Rock, include:

Terry Rodgers, Wm. G. Reese, W. K. Jordan, Louis Cohen, Thomas A. Harris, and Ewing Crawfis, all of Little Rock.

Bowie-Miller County Medical Societies had George A. Lull, Chicago, secretary-general of the A.M.A. as guest speaker at their dinner January 20 where he spoke in the interest of the American Medical Education Foundation.

Karr Shannon, Jr., formerly of Melbourne, has recently joined the Newport Hospital and Clinic.

Suggested Reading: Ben W. Saltzman's "Rotary's Golden Anniversary" — reprinted in the Journal of the A.M.A. January 22, 1955—page 372.

Charles F. Wilkins, Jr., has moved from Newport to Russellville where he has joined the Millard-Henry Clinic.

Roy E. Schirmer, Fort Smith, is president of the Southwest Allergy Forum which met January 10 in Little Rock. Tom Johnston is secretary-treasurer.

Proceedings of Societies

January elections of the Faulkner County Medical Society elevated Ed Dunaway, Conway, to the presidency; John W. Sneed, Conway, vice-president, and Cecil Dickerson, Jr., Conway, as secretary. Ray Fulmer and Clyde Rodgers, both of Little Rock, were guest speakers.

W. L. Walker, Brinkley, is president of the Monroe County Medical Society for 1955. T. G. Swain, Cotton Plant, is new vice-president, and Jere Long, Brinkley, re-elected secretary-treasurer. E. D. McKnight, Brinkley, is delegate to the Arkansas Medical Society, and J. P. Williams, Brinkley, alternate.

The Southeast Arkansas Medical Society met January 17 at McGehee with thirty-seven physicians in attendance. Joe S. and Elvin Shuffield, Little Rock, furnished the program.

The Ouachita County Medical Society met in dinner session in Camden, Thursday evening, February 3. The following program was rendered: "Intra-abdominal Cancer," Alfred Kahn, Jr., Little Rock; "Peptic Ulcer Problems," Henry Hollenberg, Little Rock.

R. B. Robins, Secretary.

The Craighead-Poinsett County Medical Society met February 2nd in Jonesboro. Robert Ruch, of Memphis, spoke on "Obstetrics." Steve Turnbull, also of Memphis, spoke on "Pediatrics."

Fifth Councilor District

Paul Sizemore, Magnolia, is the new year's president for the Fifth Councilor District Medical Association. Jack Sheppard, El Dorado, is vice-president, and L. V. Ozmont, Camden, secretary. D. E. White, El Dorado, is Councilor for the District, and G. C. Burton, El Dorado, is his alternate. Dentan A. Cooley, Houston, Texas, addressed the Society January 13 on Surgery of Aortic Diseases, and the use of aortic transplants.

Two thousand visitors attended the opening of Yell County Hospital in Danville on January 9. Visiting physicians from Russellville, Fort Smith, and Little Rock, took part in the ceremonies.

L. Kellmer Champion was named president of the Arkansas County Medical Society at the January meeting at DeWitt. W. T. Champion was elected secretary. S. A. Drennen was named delegate to the state society and M. C. John was chosen alternate delegate.

James R. Fall, West Memphis, and A. C. Parker, Clarkedale, have been elected to the two medical organization leadership posts in Crittenden County for 1955. Fall has been renamed as chief of staff for Crittenden Memorial Hospital at West Memphis and Parker has been named as president of the Crittenden County Medical Society. W. J. Wright, Earle, has been named as vice-president, and Milton Lubin, Turrell, as secretary. Milton Deneke, West Memphis, was named to represent the county society at the state medical society meeting in May.

At the January 17 meeting, the following officers of the Arkansas Psychiatric Society were elected: Louis A. Cohen, Little Rock, president; Ewin S. Chappell, Little Rock, vice president, and W. B. Hawkins, North Little Rock, secretary and treasurer. Daniel Blain, Washington, D. C., Medical Director of the American Psychiatric Association, was elected an honorary member of the Arkansas Psychiatric Society.

W. B. Hawkins, Secretary-Treasurer.

WOMEN'S AUXILIARY

The Woman's Auxiliary to the Pulaski County Medical Society met January 19, 1955, for a luncheon meeting at the Y. W. C. A. The hostesses for the day were in charge of Mrs. Eugene Crawley, and lovely spring flowers in wicker baskets were used on the luncheon tables. The program on "Medical Legislation" was arranged by Mrs. Jerome Levy who presented the speakers, Dr. Joe Shuffield and Mr. Eugene Warren.

Mrs. James Newbill,
Publicity Chairman.

The Women's Auxiliary to the Jefferson County Medical Society met on January 7th in the home of Mrs. W. T. Lowe. Co-hostess was Mrs. W. H. Bruce. Reports were heard from several committee chairmen on plans for the Ninth Annual Davis Hospital Style Show and Tea to be presented on Feb. 12th. Mrs. Howard Stern called attention to a series of 13 health programs prepared by the American Medical Society, dealing with the problems of older people, which will be heard over a local radio station beginning Sunday, Jan. 16th. Several issues concerning medical problems which are pending in coming legislation were discussed by Mrs. Louis Hundley. Members were urged to contact their representatives with opinions on the issues.

The following officers of the Auxiliary to the Jefferson County Medical Society are making plans for the annual style show given by Auxiliary members on Feb. 12th at Hotel Pines: Mrs. Ross Maynard, president; Mrs. E. L. Hutchison, publicity chairman; Mrs. Calvin Simmons, treasurer; and Mrs. W. J. Wilkins, Jr., vice-president and chairman of this year's style show. This band of doctor's wives although a relatively small group, are very active in the life of the town of Pine Bluff and have contributed much to the Davis Hospital.

Mrs. E. L. Hutchison,
Publicity Chairman.

AUXILIARY BOARD

The Annual Mid-Term Board meeting of the Women's Auxiliary to the Arkansas Medical Society was held at the home of the State President, Mrs. Hoyt Choate in Little Rock on January 26th. A delightful luncheon was served buffet style, with business meeting following. The following counties were represented: Clark, Jefferson, Pulaski, Union, Phillips, Garland, Independence, Greene-Clay, Craighead-Poinsett, Monroe, Pope-Yell, Bowie-Miller, and Sevier.

Dr. Charles Henry, chairman of the Advisory Committee to the State Auxiliary from the Arkansas Medical Society, talked. He stressed the coming 4th Rural Health Conference to be held in Little Rock in the month of June.

Many interesting reports were given. Under the outstanding leadership of chairman of Nurse Recruiting, Mrs. W. G. Cooper, and co-chairman, Mrs. Eugene Crawley, several Future Nurses Clubs have been formed over the state.

Mrs. Erner Jones, State Mental Health Chairman, stated that the State Health Dept. is set up to have a "film fair" in any town in Arkansas that a county Medical Auxiliary will sponsor. A "film fair" is an all day showing of mental health films.

County Auxiliaries are asked to get their money into the four loan funds. Also please send in news about your county Auxiliary.

Mrs. Cecil Parkerson, president of Garland County Medical Auxiliary, and Mrs. Frank Adams, president-elect, discussed plans for the coming state convention to be in Hot Springs, Ark., on May 30, 31, and June 1st.

Mrs. Gordon Oates,
State Publicity Chairman.

Mrs. A. A. Little of Texarkana is serving on the National Nurse Recruitment Committee.

BOOK REVIEWS

Urology—Volumes I, II, and III. Edited by Meredith Campbell, M.S., M.D., F.A.C.S., Emeritus Professor of Urology, New York University. With the collaboration of fifty-one contributing authorities. September, 1954. Pp. 2,356 through Vols. 1, 2, and 3. Illustrations: 1,148 figs. $60.00 W. B. Saunders Company, Philadelphia.

A thorough perusal of Editor and Author Campbell's comprehensive new text on urology stamps it as a landmark in urology. It presents its problems and its sections in a definitive way, and has the virtue of trying to talk about one thing at a time. The editor has selected authors who know the art of writing well as well as outstanding men in the various divisions of urology.

If one were to pick an outstanding portion of the book, or author, it would probably be that on "Anomalies of the Urogenitary Tract," done by Editor Campbell himself. In this section is found a complete coverage of the many congenital findings and their diagnosis and suggested correction. This section alone is a classic monograph. As editor-in-chief Campbell also wrote the section on urology in childhood which is complete—and which contains many illustrations and diagrams.

The section of "Urology in the Female" (Sec. XII) can serve as an encyclopedia of the subject, specifically, written by Lawrence Wharton, this most important subject is covered in detail. Illustrations are well chosen and profuse. Opinions are given without a dogmatic approach. The reader is brought up to date without going off onto the tangent of experimental medicine.

It's not often that a physician can find a book that is so well written, that is complete, and that tells him what he wants to know without leading him through a maze of theories and controversial material. Campbell's Urology—with its 51 authors, is definitive, complete, authentic and valuable, to any physician who ever treats any condition affecting the urinary tract. To this reviewer, it is the best Urology ever written.

Standard Values in Nutrition and Metabolism. Erret C. Albritton, A.B., M.D., Fry Professor of Physiology, The George Washington University. W. B. Saunders Company, Philadelphia. Paper. Pp. 380. 1954. $6.50.

This statistical information is a portion of a Handbook of Biological Data being prepared under the direction of a committee of the American Institute of Biological Sciences and the National Research Council. It consists, as its name implies, of tables of percentages of many types and components of various foods and vitamins, as well as statistical data of many biological research problems.

This text is entirely a reference work—a compendium for work done by researchers in all the basis sciences. Its references are exhaustive. It is most valuable for schools and laboratories.

Pediatric Diagnosis: Morris Green, M.D., Assistant Professor of Pediatrics, Yale University School of Medicine; Julius B. Richmond, M.D., Professor and Chairman of the Department of Pediatrics, State University of New York, College of Medicine at Syracuse. First Edition. Cloth. $10.00. Pp. 436. Illustrated. W. B. Saunders Company, Philadelphia. 1954.

This text is an excellent compilation of the essential knowledge of physiology and disease as applied to clinical problems. Section Two, on the all-important physical examination in pediatrics is very thorough and offers a good differential diagnosis for both common and unusual physical findings. The third section is an outline of symptom diagnosis and is adequately indexed for easy reference. The final section on health supervision is concise and brief with numerous references for further study if desired. This book is well written and should be invaluable in interpreting signs and symptoms for the accomplishment of an accurate, early diagnosis.

With this addition to his library a physician can feel that he has the latest and the ablest in assistance. The general practitioner as well as the pediatrician will use this book every day.

U. C. MEDICAL CENTER LIBRARY
APR 25 1955
San Francisco, 22

APRIL 1955

THE JOURNAL OF THE ARKANSAS MEDICAL SOCIETY

VOL. LI No. 11

FORT SMITH, ARKANSAS

79th ANNUAL SESSION ARKANSAS MEDICAL SOCIETY
ARLINGTON HOTEL — HOT SPRINGS — MAY 30-31 - JUNE 1

consider
ILOTYCIN
(ERYTHROMYCIN, LILLY)
FIRST

wide clinical range:
80 percent of all
bacterial infections
and 96 percent of all
acute bacterial
respiratory infections
respond readily

notably safe, well tolerated

Lilly

to combat resistant bacteria...

Chloromycetin®

The rising incidence of bacterial resistance to various antibiotics constitutes a serious therapeutic problem. Many infections, once readily controlled, are now proving difficult to combat. Administration of CHLOROMYCETIN (chloramphenicol, Parke-Davis) is often useful in these cases because this notable, broad-spectrum antibiotic is frequently effective where other antibiotics fail.

"...An advantage of CHLOROMYCETIN appears to be its relatively low tendency to induce sensitization in the host or resistance among potential pathogens under clinical conditions."*

CHLOROMYCETIN is a potent therapeutic agent and, because certain blood dyscrasias have been associated with its administration, it should not be used indiscriminately or for minor infections. Furthermore, as with certain other drugs, adequate blood studies should be made when the patient requires prolonged or intermittent therapy.

*Pratt, R., & Dufrenoy, J.: Texas Rep. Biol. & Med. *12*:145, 1954.

MEDICAMENTA VERA

PARKE, DAVIS & COMPANY • DETROIT 32, MICHIGAN

THE

Journal

OF THE

Arkansas Medical Society

Owned by

THE ARKANSAS MEDICAL SOCIETY

And Published Under Direction of the Council

FOUNT RICHARDSON, M.D., Editor

316 West Dickson Street Fayetteville, Arkansas

MR. PAUL C. SCHAEFER, Business Manager

215 Kelley Bldg. Fort Smith, Arkansas

The Advertising policy of this JOURNAL *is governed by the rules of the Council on Pharmacy and Chemistry of the American Medical Association.*

EXCLUSIVE PUBLICATION—Articles are accepted for publication on the conditions that they are contributed solely to this JOURNAL.

COPYRIGHT, 1955—By The JOURNAL *of the Arkansas Medical Society.*

NEWS—Our readers are requested to send in items of news, also marked copies of newspapers containing matter of interest to the membership.

OFFICERS OF THE ARKANSAS MEDICAL SOCIETY

W. R. BROOKSHER, President....Fort Smith
L. H. McDANIEL, President-Elect....Tyronza
T. P. FOLTZ, First Vice-President....Fort Smith
ELDON FAIRLEY, Second Vice-President....Wilson
R. H. WHITEHEAD, SR., Third Vice-President....DeWitt
J. J. MONFORT, Secretary....Batesville
DANIEL H. AUTRY, Treasurer....Little Rock
T. DUEL BROWN, Speaker, House of Delegates....Little Rock
C. C. LONG, Vice-Speaker....Ozark
MR. PAUL C. SCHAEFER, Executive Secretary
215 Kelley Bldg., Fort Smith

COUNCILORS

First District—JOE VERSER....Harrisburg
Second District—HUGH R. EDWARDS....Searcy
Third District—J. MAX ROY....Forrest City
Fourth District—L. K. HUNDLEY, Chairman....Pine Bluff
Fifth District—D. E. WHITE....El Dorado
Sixth District—HARRY E. MURRY....Texarkana
Seventh District—H. KING WADE, JR....Hot Springs
Eighth District—H. ELVIN SHUFFIELD....Little Rock
Ninth District—FOUNT RICHARDSON....Fayetteville
Tenth District—J. M. KOLB....Clarksville

VICE-COUNCILORS

First District—WAYNE WORKMAN....Blytheville
Second District—JOHN SNEED....Conway
Third District—J. P. WILLIAMS, JR....Brinkley
Fourth District—H. W. THOMAS....Dermott
Fifth District—GEORGE BURTON....El Dorado
Sixth District—CHARLES YARBOROUGH....Texarkana
Seventh District—RANDOLPH ELLIS....Malvern
Eighth District—ROBERT D. JONES....Little Rock
Ninth District—LEE A. DEAN....Rogers
Tenth District—LOUIE A. WHITTAKER....Fort Smith

Notice on Form 3578-P to be sent to the Arkansas Medical Society, 215 Kelley Building, Fort Smith, Arkansas. Published monthly under direction of the Council, Arkansas Medical Society, at Fort Smith, Arkansas. Vol. LI, No. 11. Subscription $3.00 a year. Single copies 50 cents. Entered as second-class matter, Sept. 23, 1947, at the post office at Fort Smith, Arkansas, under the Act of Congress of March, 1879. Acceptance for mailing at special rate of postage provided for in Section 1103, Act of October 3, 1917, authorized August 1, 1918.

• SPECIAL FEATURES

Committee on Cancer Control.... 261

Texarkana's Maternity Program for Indigents.... 262

What is the Best Way to Treat Ringworm of the Scalp?.... 266

Arkansas Traveling.... 271

Concerning Cerebral Circulation 272

Public Relations.... 273

• FEATURES

Tuberculosis Abstracts.... 274

Obituary.... 275

Proceedings of Societies.... 276

Personal and News Items.... 277

Woman's Auxiliary.... 278

Book Reviews.... 280

The JOURNAL
OF THE ARKANSAS MEDICAL SOCIETY
PUBLISHED MONTHLY UNDER DIRECTION OF THE COUNCIL
Vol. LI April, 1955 No. 11

Committee on Cancer Control

C. A. ARCHER, M.D., Chairman

ENDOCRINES IN PROSTATIC MALIGNANCY

While radical surgery following early detection offers the only hope for cure of prostatic cancer, these cases are in the minority and most patients are seen with extension of the malignancy beyond the capsule and with metastatic changes. Some of these may respond to proper administration of endocrines, and, if not regressing in sufficient degree to warrant surgical removal, may attain effective control and prolongation of life. Urologists, in general, do not advocate immediate orchidectomy and suggest that this procedure be reserved as an "ace-in-the-hole" when further progression of the malignancy and pain from metastatis ensues. Figures now available indicate that regression of inoperable malignancy of the prostate may be more prolonged if endocrines and orchidectomy are employed sequentially and not simultaneously.

TEXARKANA'S MATERNITY PROGRAM FOR INDIGENTS*

Joint Venture of Bowie & Miller County Health Units, Bowie-Miller Counties Medical Society Staff of St. Michael's Hospital

WM. B. HARRELL, Texarkana

Since Texarkana is located on the Texas-Arkansas state line, pre-natal clinics have in the past operated at the Bowie County (Texas) Health Unit and the Miller County (Arkansas) Health Unit. Both of these Health Units are located in the confines of the city proper but serve the population of both counties respectively. These clinics were established for the indigent or those expectant mothers who were unable to pay private physicians and were, therefore, delivered by midwives. The Health Department per se did not provide service although they did assist the patient in planning for home delivery and in some cases helped to provide hospitalization.

In 1953 many of the local practicing physicians questioned the justification of the continuation and expansion of these pre-natal clinics. They felt that a local hospitalization plan for indigent mothers would appreciably reduce the number of midwife deliveries and serve the best interests of the patient. In view of the fact that the St. Michael's Hospital was inaugurating a Residency Program in General Practice and that the approval of this program depended upon the operation of an out-patient maternity clinic, the Medical Society appointed a committee to study the situation and make recommendations. The committee, composed of Dr. J. W. Jones, Dr. William B. Harrell, and Dr. Eugene T. Ellison, had several informal talks and also contacted all of the officials of the County and State Health Departments in order that the approval and aid of both State Health Departments would still be extended to the care of maternity patients even after the Clinic was moved into the St. Michael's Hospital to augment the Residency Program. A liaison was established with the hospital authorities who agreed to take patients for a fee which was about the same as that charged for midwife care at home; with, of course, reservations that more seroius cases would be expected to have some funds provided through welfare associations or other means.

The Clinic would have three real principles in mind. The first would be to offer to the public improved care of indigent patients with hospitalization for at least those for whom delivery might be complicated. The second principle would be to suppress midwife care of maternity cases which, although supervised by County Agencies, is not considered adequate care for deliveries. Third, of course, would be to bring hospital standards up to where a Residency Program could be initiated. In addition to this, it was felt that a Residency Training Program would increase the efficiency of the personnel of the hospital including the nurses and staff physicians. The appointed committee, after a very careful study, made the following recommendations:

1. A Maternity Clinic be established at the St. Michael's Hospital in space provided by the hospital. All laboratory and X-ray facilities of the hospital be at the disposal of the Maternity Clinic.
2. The Medical Staff of the Maternity Clinic consist of two general practice residents and the nineteen active staff physicians in the Ob-Gyn Department of St. Michael's Hospital.
3. Both the Bowie and the Miller County Health Units furnish one nurse for the Clinic.
4. A Medical Social Worker also be placed on the staff of the Maternity Clinic to screen the patients. Patients be referred either by one of the health units or by a private physician. A patient must live in either Miller or Bowie County and be an indigent patient. If she reports directly to the Clinic without reference, she is to be screened by the volunteer Medical Social Worker, Nurse, or Doctor and in each instance the Nurse, Doctor, or Social Worker is to use his own judgment as to whether or not the patient is indigent. After having been passed by the Nurse or Social Worker, if any patient is known by the Doctor and to his own knowledge is able to pay, she can still be refused free medical service.
5. The Clinic be held each Thursday starting at 12:30 P. M.
6. Pregnant patients reporting to the hospital without a private physician and who are able to pay, become the private patient of the obstetrician on call.

* Chairman's Address, Obstetric and Gynecology Departmental Staff meeting which was held in conjunction with Obstetrician's Mass of Thanksgiving—Second annual celebration to express gratitude to Almighty God for the blessings bestowed on the hospital's Obstetrical Department—Rev. Patrick M. Lynch, Chaplain of St. Michael's Hospital Celebrant of the Mass, January 8, 1955.

7. Those physicians on the active staff of the Ob-Gyn Department of the St. Michael's Hospital take both the delivery and clinic service for one month.
8. The Chairman of the Pediatric Service make available pediatric consultation and newborn care by members of that department in whatever rotation they decide to use. It was suggested that this pediatric staff member on Maternity Clinic call be notified at the time of delivery of the baby and this pediatrician then be responsible for the care of the baby.
9. All patients admitted to this Maternity Clinic be charged a fee of $25 by the hospital. This fee of $25 represents the same amount, approximately that would be paid a midwife.
10. The hospital accept any patient admitted to the Maternity Clinic free of charge if she is not able to pay the $25 fee.

Since this Maternity Clinic has been in operation for one year, certain problems arose concerning the eligibility of patients for this Clinic. In order to organize a procedure for establishing eligibility for maternity care, the first step was to make a form questionnaire containing as much pertinent social data as possible. This was to be a guidepost to a patient's ability or inability to pay for private medical care.

Two chief factors determine an individual's eligibility—residential and financial. First, a person must live in either Bowie or Miller Counties and, secondly, their income must be insufficient to pay for private pre-natal and post-partum care.

The residential factor has not presented a great problem. There have been several, perhaps four or five, applications for clinic admission by patients who hear of the clinic through friends or relatives and visit these relatives for an extended time in the hope of obtaining free medical care. However, these few cases have been detected and referred to private care.

The factor of determining a person's ability to pay has been the main problem. Indigency in itself is difficult to decide in terms of minimum or maximum income. For example, a man earning $40 a week with a wife and one child is certainly not considered indigent. On the other hand, if this man has six children in addition to himself and wife, he may be able to provide the necessities of food, clothing, and shelter; but will find himself unable to pay medical bills. He would probably be able to pay the $25 delivery fee through the Clinic but not a doctor bill plus a hospital bill. It seems to be this type of case which has caused the most controversy. In these cases whenever possible, the doctor on service has been consulted for the final decision; if the patient was not originally referred by a doctor, which is the preferred procedure.

A large number of cases have incomes averaging $25 to $35 per week with large families. Another group have little more than $10 to $18 per week as average income and still another has only Social Security. Incomes are verified by employers only when a statement of wages seems questionable. Patients are also requested to bring any insurance policies they have for hospitalization and these are found without exception to pay $6 per day for a maximum of five days which would not pay a patient's $25 fee for delivery if the patient remained only three days. One of the problems that should be clarified is the admission of certain Army and Navy Dependents who are entitled to free care in Army hospitals where those facilities are not readily available. Insofar as possible to determine, the patients admitted for clinic care have been unable to pay for private medical care on the basis of facts presented to the Medical Social Worker.

Because of the fact that the Maternity Clinic had just completed its first year of operation in January, 1955, it was felt that it would be appropriate to discuss some of the problems encountered. Also, there might be other hospitals in the state which might want to institute such a program.

There was a total of 958 clinic visits to the maternity conference for the year with a monthly average of 79 patients. One hundred forty patients delivered in a hospital with a monthly average of 12 patients. Of the total number of deliveries in the hospital, there were one maternal death, four stillbirths, and six neonatal deaths.

The maternal death was that of a 29-year-old colored female, gravida 7, para 5, who gave history of no difficulty with previous pregnancies or labors. She did, however, have one child die at the age of 3 years with hydrocephalus. Her last menstrual period was 9/25/53 and she was expected to deliver on 7/2/54. During the pre-natal course her blood pressure ranged from 100/60 to 130/80. There was no proteinuria or edema at any time. The result of blood counts and urinalysis were within normal limits. Her blood serology was negative and she gave history of receiving antiluetic therapy by USPHS

(Hot Springs) in 1945. The Gc culture was negative. On June 29, 1954 at 2 A. M. the patient went into labor spontaneously for a total of 2½ hours. She was admitted to the hospital, prepared in the usual manner, and S. S. enema administered with good results. On admission the patient's temperature was 98.6, respiration 20, pulse 78, and blood pressure 130/80. The FHT was present in the LLO. Presentation was vertex, and there were uterine contractions every five to six minutes of thirty seconds duration. At 4:00 A. M. the pains became very severe and Demerol and Scolopoline were administered. The cervix became fully dilated at 4:30 A. M. and the membrane ruptured spontaneously. The patient was removed to the Delivery Room and a precipitate delivery occurred just as the patient was placed on the table. The female infant appeared to be normal and breathed spontaneously. The placenta delivered intact and Ergotrate was administered intramuscularly. The uterus contracted down well and inspection of perineum and vagina revealed no lacerations. Just as the patient was to be moved from the Delivery Room, she started hemorrhaging profusely from the uterus. A gas oxygen anesthetic was administered and the cervix was inspected for lacerations. There appeared to be no lacerations of the cervix or vagina and the uterus was then explored manually. No rupture was noted in the uterus. The uterus was packed tight and at this time blood transfusions were begun and infusion of Pitocin, 1 cc in 500 cc of 5 per cent dextrose, was given without effect. The uterus was repacked with ten yards of plain gauze and manual massage of the uterus maintained. A fresh solution of Pitocin and Dextrose was prepared and given without effect. About this time it became evident that the patient was bleeding through the pack and it was also noted that the blood was not clotting. After consultation it was decided that it would be unwise to attempt a supracervical hysterectomy. At this time we were able to obtain 2 gms of Fibrinogen from the pharmacy which was administered at 6:30 A. M. An unsuccessful attempt was made to replace blood loss; but the patient never recovered from shock and at 8:00 A. M. she expired. Autopsy and laboratory findings confirmed a diagnosis of Afibrinogenemia. It was the opinion of the staff members that this case could possibly be one of those rare instances where afibrinogenemia occurs following a tumultuous, precipitate labor causing an increase intrauterine pressure which acts as the mechanism for passage of amniotic fluid into the maternal circulation.

In considering the fetal mortality for the past year, the causes of the still-births were as follows:

1. Prolapsed cord 1
2. Fetal anomalies incompatible with life 1
3. Cause undetermined (No fetal heart beat on admission) 2

The causes of the neonatal deaths were listed as follows:

1. Prematurity 5
2. Erythroblastosis 1

It was of interest to find that no Cesarean Sections were performed during the first year of the Maternity Clinic.

In this series of deliveries two infants had Erythroblastosis fetalis. One infant died shortly after delivery; the other survived following an exchange transfusion. In order to care for infants with Erythroblastosis, a staff pediatrician is always available on call. A sterile prepared tray is always on hand. The indications for transfusion are 1) an immature infant (gestation less than 38 weeks) with a cord hemoglobin below 15.0 gms and a positive Coombs test; 2) clinical evidence of Erythroblastosis with significantly positive laboratory work such as a positive direct Coombs test, a falling hemoglobin below 15 gms and a rising bilirubin determination in excess of 3.0 mg per 100 cc, an infant's blood type Rh positive and the mother's Rh negative, a rising maternal antibody titre of 1:64 or higher during pregnancy; 3) any infant who is Rh positive and has a positive Coombs test with an unfavorable past history of previous siblings having some form of Erythroblastosis fetalis. The amount of blood exchanged is usually 500 cc. The blood used should be type specific Rh negative or O negative with added group A and B substance and serial Hg determinations should be made up to 3 months of life. If the Hg drops below 7.0 gms, a repeated small transfusion may be needed. About ten per cent of babies may need a second exchange transfusion if the bilirubin rises above 20 mg per cent after the first exchange transfusion.

The department of Anesthesia at the St. Michael's Hospital has available an anesthetist on obstetric call at all times. Most of the patients received general anesthesia consisting of Cyclopropane or drop ether in addition to routine demerol and scopolamine analgesia. Some of the patients received seconal in addition to the demerol and scopolamine.

The staff feels that early ambulation of patients is indicated, and most of the patients are walking by the second post-partum day. There were occasional infected episiotomies in this series of cases but no serious post-partum complications.

Most of the deliveries were performed by the general practice resident under the supervision of the staff physician on call. There are two general practice residents who rotate on call every other night and weekends. If at all possible, both residents are required to be present every Thursday at the Maternity Clinic.

Because of the relatively small series of cases at present, a complete statistical breakdown of results would be of little interest now although some statement was needed concerning the maternal and fetal deaths.

During the past several years patients who were registered in the Maternity Clinic could not, for one reason or another, get to the hospital for delivery. In fact, there were 54 midwife deliveries recorded in Bowie and Miller Counties during the past year from registered Clinic patients. It appears to be a strange coincidence that such a high percentage of Clinic patients would continue to have midwife deliveries when hospitalization was offered them. On the other hand, the maternity program has only been in effect for one year and in the future the number of midwife deliveries may be reduced to a much larger extent.

The total cost of this program to the St. Michael's Hospital for the past year was $10,333.38. Since $3,032.14 was paid to the hospital in $25 fees, this leaves a final cost of $7,301.24 to the hospital for the program.

We would have been unable to establish the Maternity Clinic without the co-operation and assistance of the following:

1. J. F. Williams, Health Officer, Miller County.
2. H. K. Harrison, Health Officer, Bowie County.
3. Sister Mary Emerita, Administrator, St. Michael's Hospital and her Staff of Sisters.
4. Frances Rothert, Director, Maternal and Child Health Division, Arkansas State Board of Health.
5. C. F. Moore, Jr., Director, Maternal and Child Health Division, Texas State Health Department.
6. Department of Ob-Gyn Staff, St. Michael's Hospital.
7. Department of Pediatrics Staff, St. Michael's Hospital.
8. Mrs. Jo Ann Barham, B.A., M.S.W. (Medical Social Worker.)
9. Mrs. Martha P. Welch, R.N., P.H.N. (Arkansas).
10. Mrs. Annie Maie Seymour, R.N., P.H.N. (Arkansas).
11. Mrs. Frances Line, R.N., P.H.N. (Texas).
12. Mrs. Helen McNeil, R.N., P.H.N. (Texas).
13. Miss Kate Cargile, Volunteer Auxiliary Worker.
14. N. Chan, Resident Physician, St. Michael's Hospital.
15. J. R. Ramirez, Resident Physician, St. Michael's Hospital.
16. Bowie-Miller Counties Medical Auxiliary Volunteer Workers.

WHAT IS THE BEST WAY TO TREAT RINGWORM OF THE SCALP?

CALVIN J. DILLAHA *

Beginning about 1940 the United States came to grips with a virulent pandemic of ringworm of the scalp. Originally the northern and eastern states, particularly the metropolitan areas, were confronted with thousands of cases in children (1). In time the pandemic involved the middle-west, and by 1947 approximately 4,000 cases were estimated to be present in St. Louis, Missouri (2). Gradually the epidemics waned in those areas but were not there contained, for the infection has now spread to the South. Recently in several localities in Arkansas large numbers of cases have been reported, and it is quite likely that the infection now smoldering in other areas of the state will soon demonstrate heightened activity. It is, therefore, appropriate at this time to review our present knowledge of ringworm of the scalp with emphasis on adequate means of diagnosis and a practical method of therapy.

DEFINITION: Ringworm of the scalp may be defined as a fungus infection primarily of the hair shaft caused by a species of both Microsporum and Trichophyton. Eventually the infection so weakens the hair shaft that it is easily broken, and if many hairs are involved, patches of partial alopecia develop. These same organisms produce ringworm of the non-hairy skin which readily responds to treatment, but when they attack the hair shaft and its root, they produce a disease at times characterized by chronicity and resistance to therapy. Although ringworm of the scalp may involve any age, it is predominantly a disease of children and adolescents up to the age of 16. A natural immunity develops during puberty particularly to the organism causing epidemic tinea capitis. For this reason the disease is uncommon in adults. The Caucasian and the Negro are equally susceptible to the infection. In epidemics of ringworm of the scalp there is a sex predominance of approximately ten to one of male over female according to published figures (1, 3) and experience in the Arkansas epidemic.

Ringworm of the scalp presents a highly variable clinical picture. There may be minimal or widespread involvement of the scalp hair without visible evidence; there may be single or multiple patches of partial alopecia containing many broken off hairs in association with a mild scaling and slight erythema of the scalp; there may be small patches of alopecia, scarring, and atrophy of the scalp in which broken off hairs are present in the follicles, giving the appearance of "black dots;" there may be diffuse marked scaling and sparsity of the hair; or there may be one or more acutely inflamed nodules with marked suppuration and crusting. This latter lesion is known as a kerion. In general, the clinical picture present in any particular case is a reflection of the type of fungus present. Therefore, the clinical varieties of ringworm of the scalp are best classified according to the organism present.

ETIOLOGIC FUNGUS:

Microsporum audouini: The non-inflammatory variety of tinea capitis of children is seen with this organism, due to the ability of the organism to live in the scalp in equilibrium with the host. This organism is the etiology of the present epidemic and is, therefore, the most common cause of tinea capitis in Arkansas. **It may reside in and involve large or small portions of hair for many months without visible clinical evidence or symptoms.** This patient unknowingly acts as a source of infection for his classmates and playmates through objects of mutual contact. Sooner or later, however, the infection so weakens the hair shaft, that it is easily broken off leaving a patch of partial alopecia containing many broken hairs. It is at this point that medical attention is sought. Often moderate scaling and slight erythema are present on the scalp in the areas of alopecia and independent thereof. Occasionally marked inflammation and swelling develops in the scalp leading to shedding of the infected hairs and spontaneous healing of the disorder. During puberty the disease may resolve spontaneously due to a natural immunity developing from changes in the sebum of the scalp coincidental to puberty (4). However, if the changes in the sebum do not take place, and if untreated, the infection may last from several months to several years, depending upon the circumstances of the individual case (5).

Microsporum canis: This organism produces the sporadic case of inflammatory ringworm of

* Read before the 78th Annual Session of the Arkansas Medical Society, Fort Smith, Arkansas, April 20, 1954.
* Assistant Clinical Professor of Medicine (Dermatology), School of Medicine, University of Arkansas.
From the Division of Dermatology, Department of Medicine, School of Medicine, University of Arkansas.

the scalp (kerion). When this patient is first seen, markedly inflamed, boggy, erythematous, single or multiple nodules of the scalp are usually present. Follicular pustules may be seen within the nodules. Once fully developed, the inflammation and suppuration result in a spontaneous loss of the infected hairs and healing of the process within approximately eight weeks. Occasionally Microsporum canis infections may initially be non-inflammatory and closely simulate a Microsporum audouini infection. This infection is usually contracted from a cat or dog and is not as a rule transmitted from child to child.

Rare Forms of Ringworm of the Scalp: There are several organisms that may cause rare forms of ringworm of the scalp. Microsporum fulvum produces tinea capitis with a clinical picture and course similar to Microsporum canis. Trichophyton Schoenleini infection, commonly known as favus, has been seen in Arkansas on only two occasions of which I am aware. Doctor Davis Goldstein (6) reports that he saw one case several years ago, and the author recently observed three cases in one family. Several cases have been reported in Oklahoma (7). The clinical picture in favus is characteristic; there is generalized cup-shaped scaling of the scalp, sparse hair growth, atrophy, and scarring, and if the case remains untreated, permanent loss of much scalp hair eventually takes place. Favus is commonly a familial disease among immigrants from middle and eastern European countries where the disease abounds.

Trichophyton tonsurans infection or "black dot" ringworm of the scalp is gradually spreading east and north from Mexico. It is now seen frequently in Texas and in the other states bordering Mexico (8). To my knowledge it has not been reported in Arkansas until recently when three cases were discovered in children (9). Clinically the infection closely simulates Microsporum audouini infections but lacks the characteristic fluorescence, or there are patches of alopecia containing "black dot," the remains of broken off hairs within the follicles. Atrophy and scarring may be the end result of this type of infection, since there is little tendency to spontaneous healing. "Black dot" ringworm may occur at any age. Other organisms of the trichophyton group such as Trichophyton mentagrophytes may rarely involve the scalp hair also. This type of infection is usually contracted from cattle and produces an inflammatory self-healing disorder (10).

DIAGNOSIS: The presence of such positive findings as partial alopecia, broken off hairs, or inflammatory nodules of the scalp in a child below the age of fifteen usually establishes the diagnosis of tinea capitis. However, the absence of hair loss, etc., does not mean that ringworm is not present, for as previously mentioned, ringworm of the scalp may exist with little or no visible evidence in natural light. Therefore, examination under filtered ultraviolet (Wood's light) is essential in any suspected case. The infection, whether visible evidence is present or not in natural light, is easily detectable by the characteristic green fluorescence present in the infected hair shaft or the root of an epilated hair. **This Fluorescence is diagnostic.** It is obvious then that a Wood's light or a suitable substitute such as a Purple-X bulb is an essential tool for any clinician attempting to diagnose or treat ringworm of the scalp.* It must be noted, however, that in markedly inflammatory lesions fluorescent hairs may be sparse or completely absent. This may be overcome to some extent by epilation of a few hairs and finding the fluorescence in the hair roots. In rare infections of the Trichophyton group, the characteristic green fluorescence is not seen, the exception being infections due to Trichophyton Schoenleini. The use of the Wood's light is not only invaluable in the diagnosis of ringworm of the scalp, but also in determining the extent of involvement of the scalp and the response to therapy. Not infrequently a child with a patch of partial alopecia may have the patch correctly diagnosed and treated, only to have a "recurrence" later.

This is due to an additional area of involvement present at the same time as the treated area, but in which alopecia or other visible evidence was absent and therefore untreated. At the time of the initial visit, examination under the Wood's light would have determined the true extent of the infection. If manual epilation is used in treatment, the Wood's light serves to point out the infected hairs which are to be removed. Periodic examination of the case under treatment with the Wood's light affords a simple and effective means of judging the result of therapy and the presence of cure. Examination under the Wood's light is the only effective means of determining presence of cure in Microsporum audouini infections. **The importance of the Wood's light in the diagnosis and**

* An economical and effective Wood's light is the black-ray, model X4, manufactured by Ultraviolet Products, Incorporated, Pasadena, California. It is available through most surgical supply houses. The Purple-X bulb is manufactured by Westinghouse Electric Corporation. Due to the high operating temperature, it can be used for only short periods of time. Protective housing and shielding of the bulb must be used. This bulb is not suitable for screening of large numbers of children.

treatment of tinea capitis cannot be overemphasized.

MICROSCOPIC MOUNTS AND CULTURES: Microscopic examination and culture of infected hairs is not necessarily indicated in the presence of the characteristic fluorescence. However, in the absence of fluorescence both may be necessary to establish a diagnosis. Although not essential, routine cultural determination of the exact organisms present may at times give invaluable information as to the prognosis and therapy required. Culture is essential, however, in any case of ringworm of the scalp to be subjected to X-ray epilation for reasons to be pointed out later.

It is not my purpose here to discuss the mycology of the organisms found in ringworm of the scalp, but it is worthwhile to mention that they are easily cultured and differentiated on gross examination or more precisely on microscopic examination of the cultured material. Sabouraud's media kept at room temperature is the standard procedure.

DIFFERENTIAL DIAGNOSIS: Ringworm of the scalp is the most common cause of hair loss in children (11), and the diagnosis should be so considered until proven otherwise. The presence of baldness in a child in the absence of the characteristic fluorescence and repeated negative cultural and microscopic studies suggests alopecia areata, trichotillomania, or one of several other rare disorders of the scalp. Both alopecia areata and trichotillomania are uncommon in children, but nevertheless are occasionally seen. Alopecia areata is characterized by rounded well demarcated patches of hair loss. Trichotillomania, a neurotic habit, is characterized by a patch of alopecia with a bizarre shape. The patient frequently readily admits pulling the hair.

TREATMENT: **The essential procedure in the management of ringworm of the scalp is removal of the infected hair.** Presently available fungistatic agents are quite effective in treating ringworm other than of the scalp, but will not penetrate to spores present in a hair shaft above the surface of the skin or to the organisms on the hair root. Therefore, it is impossible to kill the fungus in a hair and have the hair remain intact and healthy by the application of such agents. To reiterate, removal of the infected hair from the host is the only means of elimination of the infection. This may be accomplished by epilation resulting from spontaneous shedding, manual pulling, or X-ray therapy. Spontaneous epilation is apparently the end result of an immunologic response leading to the formation of antibodies on the part of the host (12). This reaction is characterized by inflammation, suppuration, loosening, and eventual loss of the infected hair. As previously mentioned, it is commonly seen in infections due to Microsporum canis, Microsporum fulvum, Trichophyton mentagrophytes, and occasionally in Microsporum audouini, Trichophyton Schoenleini, and Trichophyton tonsurans. Varying amounts of scarring may follow this reaction.

Manual Epilation: Manual epilation in combination with other local measures has become the treatment of choice of epidemic ringworm of the scalp (Microsporum audouini) in the past several years. Experience of a number of workers has shown that epidemic ringworm can be cured as quickly if not more quickly in most cases by manual epilation and local therapy than by X-ray epilation (13). This has led to the abandonment of X-ray epilation by many dermatologists in the treatment of the average case of tinea capitis due to Microsporum audouini. One of the reasons for the better results with manual epilation in the past few years is the apparent lessening in the virulence of Microsporum audouini infections (14). The impression is that Microsporum audouini infections of today are more likely to respond to local treatment and may at times undergo spontaneous cure in contrast to those cases seen in the early 1940's (5).

Manual epilation is accomplished by removal of the infected hairs with forceps using the Wood's light to determine the presence of infection. It may be done by the physician if the hairs are not numerous, or if many and time consuming, by the parents at home on a day to day basis using the inexpensive Purple-X bulb or a small Wood's light.

X-ray Epilation: In the hands of a qualified dermatologist, X-ray epilation is indeed an effective and safe procedure and has for many years been the standard remedy in non-inflammatory ringworm of the scalp. The Kienbock-Adamson technique, a precise method for total epilation of the entire scalp, is the method in common use. Partial X-ray epilation has no place in the treatment of ringworm of the scalp since the cure rate is so low due to incomplete removal of the infected hair. Cultural diagnosis of any case of ringworm of the scalp is essential when X-ray epilation is contemplated (15). Since it may at times be impossible to determine the type of ringworm present in a particular patient

on a clinical basis alone, it seems unwise, uneconomical, and possibly hazardous to subject a patient with an infection that might undergo spontaneous healing to X-ray epilation. It is the present opinion of many dermatologists that X-ray epilation should be reserved for those infections due to Trichophyton tonsurans, Trichophyton Schoenleini, and the occasional unresponsive case of Microsporum audouini, in all of which the diagnosis has been confirmed by culture of the organism.

LOCAL MEASURES: Although, as previously mentioned, locally applied fungistatic agents do not penetrate to the infection, they are nevertheless an essential adjunct to the treatment of tinea capitis. They may prevent spread of the infection by killing organisms exposed on the surface of the hair and on the scalp. In addition, certain ones may in themselves produce and promote the inflammatory reaction that leads to spontaneous healing. This spontaneous healing is undoubtedly what we have all observed in cases of ringworm of the scalp that have healed with little more than the application of the fungistatic ointment. There are, of course, many preparations on the market designed for treatment of ringworm of the scalp. One which has been thoroughly evaluated both in the laboratory and in the patient and which today is the preparation most widely used by dermatologists is marketed under the trade name of Salundek (Wallace & Tiernan). It contains zinc undecylenate, 25 per cent; undecylenic acid, 2 per cent; and salicylanilide, 5 per cent.

In addition to manual epilation and the application of fungistatic ointments, other local measures include shaving the head and keeping it shaved, wearing a tight fitting cap at all times, and vigorous washing of the scalp twice daily with soap and water using a washcloth or brush.

Incorporating the measure now considered the treatment of choice, the average case of Microsporum audouini infection might be managed somewhat as follows: If one or more large patches are present, then the entire head is shaved. If the patches are small and not widely scattered, then the hair for an inch around the area is shaved. The involved area should be scrubbed well twice daily with soap and water using a washcloth or brush. A fungistatic ointment such as Salundek is applied and rubbed in well after washing. A tight fitting cap (not a nylon stocking cap) should be worn at all times to prevent dissemination of infected hairs. Manual epilation of the infected hairs by a physician or parent at intervals as indicated is carried out. The usual course of such treatment averages about three months (16). If, during the period of treatment, an inflammatory reaction develops, then the application of the fungistatic ointment and the vigorous washing may be discontinued. Secondary infection commonly develops, and systematic and local antibiotics may be indicated along with local hypertonic hot packs. 3-5 per cent Ammoniated mercury ointment is at this time of particular merit since it may be fungistatic as well as bacteriacidal. A good criterion for cure consists of three negative examinations under the Wood's light at monthly intervals with cessation of therapy at the time of the first examination. Many times parents, particularly of the lower or modest income groups, will be unwilling to accept a three months course of therapy. Many of them will have heard of proprietary or home remedies which they feel sure will quickly eradicate such an infection. Usually a careful explanation of the purpose of therapy will "sell" the parents on the virtue of proceeding with this course of therapy.

PREVENTION: Since large numbers of cases may occur in an area of epidemic, control of the disease obviously is a public health problem. The most important measure commonly employed to combat epidemic ringworm of the scalp is the periodic survey of school children under the age of fifteen with a Wood's light (1, 17). This affords a means of detecting the infection in the child unaware of its presence, who unknowingly is serving as a source of dissemination of the disease. Since Microsporum audouini infections have reached epidemic proportions in several areas of Arkansas, it would seem appropriate that a statewide program of screening of children's scalps be instituted through the school nurses or similar personnel trained in using the Wood's light. Such surveys would not necessarily overly tax the school nurse or similar personnel since a person trained in using the Wood's light can usually examine seventy-five to a hundred children in one hour, and such surveys would not have to be repeated any oftener than every three or four months. It is worthwhile to emphasize at this point that the Wood's light examination is essential if early cases without visible evidence in natural light are to be uncovered. Once the child is under treatment and wearing a tight fitting cap at all times, he should be allowed to return to school.

Theatre seats with their plush upholstery, particularly those closer to the screen which are commonly frequented by children who sit with

the backs of their heads on the seat, have been incriminated as a source of contagion. Several authors state that this may be a source of spread if the seats are grossly contaminated with infected hairs (1, 2, 11). Another author points out that the seats were not considered important in the epidemic which he studied since the seats were not grossly contaminated with infected hairs (3). This author recently examined twenty or thirty seats in one theatre in an area of epidemic. Using a Wood's light, one fluorescent hair on the back of a seat was found along with a number of small green fluorescing granules, all measuring one-half milimeters in diameter or less. Cultures of the one hair and four out of the five small granules were positive for Microsporum audouini and were identical with the organism grown from the scalps of infected children in this community. Thus it would appear that gross contamination with infected hairs is not essential for theatre seats to act as a source of Microsporum audouini infection. That theatre seats act as a source of contagion is also substantiated by the observation that in many cases the infection is localized to the occipital scalp hair, the portion of the head resting on the theatre seat. Barber shops for obvious reasons have also been incriminated as a source of infection (3). It has at times been suggested that barber shops and theatres be closed to prevent the dissemination of ringworm of the scalp. This would seem unjust, ineffective, and actually unneeded if adequate school surveys were carried out and all infected children placed under treatment. Once all cases in a locality are under treatment, effective decontamination of theatres would then destroy their reservoir of infection. It would be unlikely that a child under proper treatment would again infect this area. There is, to my knowledge, no effective and practical means of rapidly killing fungi on barber instruments. However, ordinary measures for cleaning such instruments and preventing accumulation of hair on them will in all likelihood suffice to prevent infection of others.

SUMMARY: The pandemic of ringworm of the scalp beginning in the United States about 1940 has now spread to Arkansas. The Wood's light is an essential tool for the diagnosis and treatment of ringworm of the scalp. The average case of epidemic ringworm of the scalp is best treated by manual epilation of the infected hairs, appropriate shaving of the head, application of a fungistatic ointment, washing the scalp well twice daily, and wearing a proper snug fitting cap. Children under treatment should be allowed to remain in school. The measure most likely to control an epidemic of ringworm of the scalp is periodic surveys of school children's scalps with the Wood's light. It is proposed that such surveys be instituted in the schools of Arkansas. This enables early cases without visible evidence of the infection to be detected. Theatre seats without being grossly contaminated with infected hairs may act as a source of spread and reservoir of the infection.

REFERENCES

1. Steves, R. J., and Lynch, F. W.: Ringworm of the Scalp, J.A.M.A. 133:306-309 (Feb. 1) 1947.
2. Mitchell, J. H., in discussion on Swartz, J. H., Rockwood, E. M., and Glicklich, E. A.: A Survey of Tinea Capitis, Including Favus, Arch. Derm. & Syph. 60:486-489, 1949.
3. Schwartz, L., Peck, S. M., Botvinick, I., Leibovitz, A. L., and Frasier, E. S.: Control of Ringworm of the Scalp Among School Children in Hagerstown, Md., 1944 - 1945, J.A.M.A. 132:58-62 (Sept. 14) 1946.
4. Rothman, S., Smiljanic, A. M., and Weitkamp, A. W.: Mechanism of Spontaneous Cure in Puberty of Ringworm of Scalp, Science 104:201-203 (Aug. 30) 1946.
5. Laur, W. E.: Spontaneous Cure of Tinea Capitis Due to Microsporum Audouini, Arch. Derm. & Syph. 64:364-66, 1951.
6. Goldstein, Davis: Personal Communication to the Author.
7. Shackelford, P. O., Morgan, R. J., Young, C. J., and Lamb, J. H.: Tinea Capitis Due to Trichophyton Schoenleini (Favus), J. Okla. State Med. Asso. 46:41-42 (Feb.) 1953.
8. Howell, J. B., Wilson, J. W., and Cairo, M. R.: Tinea Capitis Caused by Trichophyton Tonsurans (Sulfureum or Crateriforme), A.M.A. Arch. Derm. & Syph. 65:194-205 (Feb.) 1952.
9. Cope, E. P.: Personal Communication to the Author.
10. Fowle, L. P., and Georg, L. K.: Suppurative Ringworm Contracted from Cattle, Arch. Derm. & Syph. 56:780-793 (Dec.) 1947.
11. Lewis, G. M.: Practical Dermatology, Philadelphia, W. B. Saunders Co., 1952, p. 103.
12. Lewis, G. M., and Hopper, M. E.: Ringworm of the Scalp, Arch. Derm. & Syph. 36:1194 (Dec.) 1937.
13. Sullivan, M., and Bereston, E. S.: Study of Topical Therapy in Tinea Capitis, J. Invest.

Derm. 19:175-78 (Sept.) 1952. Wilson, J. F.: Manual Epilation in Treatment of Tinea Capitis, Arch. Derm. & Syph. 60:347-55 (Sept.) 1949. Barlow, A. J. E., Chattaway, F. W., and Whewell, C. S.: Ringworm of the Scalp Due to Microsporum Audouini, Brit. J. Derm. 62: 251-261 (June) 1950.

14. Sulzberger, M. B., and Baer, R. L.: Editorial Comment, Yearbook Derm. & Syph. Chicago, Yearbook Publishers, 1949, p. 58.
15. MacKee, G. M., and Cipollaro, A. C., X-ray and Radium in the Treatment of Diseases of the Skin, Philadelphia, Lea & Febiger, 1946 p. 252.
16. Hopkins, J. G., Lingamfelter, C. S., Kiesselbach, M. R., and Hamilton, O. A.: Treat-Ment of Tinea Capitis with Salicylanilide Preparations, A. M. A. Arch. Derm. & Syph., 67:479-483 (May) 1953.
17. Davidson, A. M.: In Discussion on Swartz, J. H., Rockwood, E. M., and Glicklich, E. A.[2]

Arkansas TRAVELING

And Clipping Bits Here and There

"It is refreshing to hear the truth. I feel that you tell it as one who neither fears nor flatters. Take this (The Golden Cross of the Order of Guadelupe) in parting, and remember, circumstances never render impossible the right to die for a Principle."

Emperor Maximilian to General Jo Shelby. Quoted from Daniel O'Flaherty's "General Jo Shelby—Undefeated Rebel."

However, because there are so many ladders today that seek ascent to truth, the internationalists are prone to make it easy for pseudoscience and themselves by crying there is no truth. A thing is good or bad only if it works well for the new God—the State.

And so we find ourselves today, offered the promised land of social security—bewildered and afraid, because iconoclastic liberalism has carried us into the land of falling ladders.

C. F. McDonald, M.D.
Pres. Wisc. Academy of General Practice.

"If the license to practice meant the completion of his education, how sad it would be for the young practitioner, how distressing to his patients!"

Sir William Osler.

Who May Do Surgery?

From a bulletin of the Joint Commission on Accreditation of Hospitals appearing in the December letter of Dr. Harold M. Camp, secretary of the Illinois State Medical Society, we quote:

"There is no specific answer to the above question. Good surgery cannot be measured blindly by years of residency, preceptorship, or number of operations assisted at or performed. Certain individuals, no matter how long or where their training, will never become good surgeons.

"Formal resident training, College of Surgeons, Fellowship or Board certification are all excellent criteria and a physician desiring to do surgery should be encouraged to set them as his goals. The worth-whileness of the above evaluations is recognized, but the frank, brutal truth remains, however, that they sometimes, though not often, are only a piece of paper; that time can warp a man's judgment and poor health can slow the facilities of a surgeon's hands until he becomes a dangerous man in the operating room.

"Merit alone is the only criterion for judging physicians' surgical abilities. This judgment should come from those capable of judging other qualified surgeons, from those who are willing to accept the responsibility and to attest to the public and community that 'in our judgment this man is capable of doing good surgery.'

"In our present medical setup this means that a staff surgeon should be judged by those other members of the staff who have seen him work, use his judgment, and exercise his ability. It becomes a local personal equation in every hospital. It is a terrific responsibility. It can never be decided on a friendship, personality or class basis."

TRUDEAU SCHOOL OF TUBERCULOSIS 1955

Forty-first Annual Session

Despite the closing of the clinical facilities of the Trudeau Sanatorium, the forty-first session of the Trudeau School of Tuberculosis will begin Wednesday, June 1st, and continue to June 29th.

The course will cover all aspects of pulmonary tuberculosis and also certain phases of other chronic chest diseases, including those of occupational origin.

The tuition is $100, payable to the Trudeau School on or before the opening date, June 1, 1955. A few scholarships are available for those individuals who can qualify . Registrations will be limited.

Write Secretary Trudeau School of Tuberculosis, Box 200, Trudeau, N. Y.

on all 4 count

ACI

wide spectrum of effectiveness
rapid diffusion
prompt control of infection
minimum side effects

he decision often favors

ROMYCIN*

HYDROCHLORIDE
TETRACYCLINE HCl *LEDERLE*

Compared with certain other antibiotics, ACHROMYCIN offers a broader spectrum of effectiveness, more rapid diffusion for quicker control of infection, and the distinct advantage of being well tolerated by the great majority of patients, young and old alike.

Within one year of the day it was offered to the medical profession, ACHROMYCIN had proved effective against a wide variety of infections caused by Gram-negative and Gram-positive bacteria, rickettsiae, and certain viruses and protozoa.

With each passing week, acceptance of ACHROMYCIN is still growing. ACHROMYCIN, in its many forms, has won recognition as a most effective therapeutic agent.

Lederle

LEDERLE LABORATORIES DIVISION *AMERICAN Cyanamid COMPANY* Pearl River, New York

*REG. U. S. PAT. OFF.

CONCERNING CEREBRAL CIRCULATION

GUEST EDITORIAL

Medical progress is highlighting some of our misunderstandings about the circulation of the brain. These studies seem to fall into three categories:—cerebral angiography, actual measurement of cerebral blood flow with appropriate chemical studies, and correlation of clinical and pathological material. This new information does not fit into an easy to understand pattern, but nevertheless does extend our wealth of facts.

Cerebral angiography consists of the injection of radio-opaque iodine dye into the carotid vessel and then taking serial X-ray films, either one plane or bi-plane. This has proved valuable in detecting tumors and thrombosis. This is particularly helpful in detecting clots that do not give a typical pattern. For example, there may be a thrombosis of a carotid without any symptoms or signs; on the other hand, in many cases there is a typical neurological syndrome with hemiparesis of the opposite side, variable sensory loss, and visual impairment of the same side. Failure to canalize a carotid vessel if done percutaneously does not necessarily mean the vessel is thrombosed. This test is not entirely innocuous as the test itself may cause side effects —even thrombosis on very rare occasions.

By canalizing the carotid artery and the jugular veins it is possible to estimate the cerebral blood flow, cerebral arterial resistance, cerebral oxygen consumption, cerebral glucose consumption, etc. Shenkin has reviewed the clinical implications of these studies, and some of these facts are ennumerated here. For example, arterio-sclerosis in the absence of high blood pressure does not decrease cerebral blood flow. In combination hypertension and arterio-sclerosis the blood flow may decrease 30 per cent. Senile dementias are often blamed on decreased cerebral blood flow but in a series of elderly controls and senile dementias, there was no difference in blood flow. Of all the substances tried to increase cerebral blood flow, 5 per cent carbon dioxide seems to be the best; if this does not work it probably means that the vessels were maximally dilated prior to the inhalation. Surprisingly, 5 per cent CO_2 also will increase cerebro-spinal fluid pressure. Xanthines as caffeine, priscoline and nicotinic acid alone do not increase cerebral blood flow but actually decrease it! Stellate ganglion block does not increase cerebral blood flow either although it does decrease cerebral artery resistance. Motionless standing is associated with a consistent drop in cerebral blood flow, whereas during exercise there is no decrease in cerebral blood flow.

An excellent discussion of the clinico pathological relationships in cerebral arterio-sclerosis has been written by Miller Fisher. It is his concept that in normotensives, athero-sclerosis attacks principally the large vessels at the base of the brain. The involvement is patchy. The small surface vessels of the brain and the penetrating branches of the superficial vessels are not a site of athero-sclerosis in normotensives; in hypertensives athero-sclerosis pushes into these two types of vessels. The penetrating vessels do not have an anastimotic web, and if they are plugged, it results in an area of softening distal to the impediment; these penetrating vessels supply the thalamus, internal capsule, basal ganglia, etc. In the presence of hypertension athero-sclerosis involves the surface vessels, too; their anastimotic network is, however, better than the penetrating vessels. Athero-sclerosis alone is not considered the sole cause of an obstruction; it is usually athero-sclerosis plus thrombosis. Why thrombosis is initiated is a still a mystery. A search for an association between uncomplicated sclerosis and senile dementia, epilepsy, dizziness, headaches, etc. showed a poor correlation. Thus it is evident that athero-sclerosis without thrombosis or hemorrhage is not a demonstrable cause for many brain disease formerly attributed to it. Athero-sclerosis, if complicated by thrombosis or hemorrhage can lead to symptoms.

The circulatory system of the brain has characteristics that make it distinctive from the circulation through other organs. Because of these differences, it is not possible to be dogmatic about the effects of altered circulation on the physiology or pathology of the brain by analogy from the study of other organs.

Alfred Kahn, Jr., M.D.

PUBLIC Physician Patient Personal RELATIONS

It is amusing to read and hear of the passing of the family physician. There never was a time in our history in which he was so much in evidence, in which he was so prosperous, in which his prospects were so good or his power in the community so potent. The public has even begun to get sentimental over him! He still does the work; the consultants and the specialists do the talking and the writing; and take the fees! By the work, I mean that great mass of routine practice which brings the doctor into every household in the land and makes him, not alone the adviser, but the valued friend. He is the standard by which we are measured. What he is, we are; and the estimate of the profession in the eyes of the public is their estimate of him. A well-trained, sensible doctor is one of the most valuable assets of a community, worth today, as in Homer's time, many another man. To make him efficient is our highest ambition as teachers, to save him from evil should be our constant care as a guild.

Sir William Osler, 1902.

From the Files of the Council

Chairman Hundley pointed out that with the passage of the new law authorizing the combining of the three state medical boards and the elimination of the old board, it was necessary for the council to submit the names of seven physicians to fill an equal number of positions on the board. Upon the motion of Kolb and White, the council substituted the name of Max Roy for that of Joe Verser and voted to submit the names of the old members of the State Medical Board for the combined state Medical Board. The length of term of each member was decided by lot and names and terms recommended to be submitted to the Governor are as follows:

First Congressoinal District, J. Max Roy, Forrest City, 1 year; Second Congressional District, M. L. Harris, Newport, 6 years; Third Congressional District, H. J. Hall, Clinton, 2 years; Fourth Congressional District, G. O. Murphy, Jr., El Dorado, 5 years; Fifth Congressional District, W. A. Snodgrass, Little Rock, 7 years; Sixth Congressional District, Frank Burton, Hot Springs, 4 years, and Member at Large, Jeff Baggett, Prairie Grove, 3 years.

Brooksher pointed out to the Council that the physicians of Pulaski County had been most cooperative in the legislative committee's effort to win friends among the Legislature and had offered their professional services for the legislators unstintingly. He pointed out that this work was done on the behalf of all of the Medical Society and moved that letter of appreciation from the State Society be sent to the members of the Pulaski County Medical Society recognizing their work. Upon second by White, the Council unanimously directed such letters be written.

From the A.M.A.

Meet Your Colleagues Along the Boardwalk!

Physicians attending the AMA's 104th Annual Meeting June 6-10 in Atlantic City may not have much time for casual strolling along the boardwalk, but they'll find ample opportunity for catching up on the latest discoveries in medicine. AMA has lined up nearly five full days of lectures, scientific and technical exhibits and color television and motion picture presentations to give you a good "short course" in postgraduate medical education. Between 13,000 and 16,000 physicians are expected to attend the convention which will center its activities in the Atlantic City Auditorium and adjacent hotels. Headquarters will be at the Traymore hotel where the House of Delegates will convene.

Outstanding scientific features include: **A report on the Salk polio vaccine trials;** a discussion of resuscitation of the newborn for the sections on anesthesiology; symposiums on rheumatism and diabetes; fracture and fresh pathology exhibits, and a new "Queries and Minor Notes" feature. In addition, the Air Force will demonstrate its "flying infirmary" on the beach in front of the Auditorium throughout the week.

More than 325 scientific exhibits and 350 technical exhibits will be on display.

REGIONAL MEETING OF THE AMERICAN COLLEGE OF GASTROENTEROLOGY

A regional meeting of the Southern Region o fthe American College of Gastroenterology will be held in Memphis, Tenn., on Sunday afternoon, 24 April 1955. The Scientific Session will be held in The Skyway, at the Hotel Peabody, commencing at 2:00 P. M., and following the semi-annual meeting of the Board of Trustees of the College. Jerome S. Levy, Little Rock, is participating in the program.

TUBERCULOSIS ABSTRACTS

A Review for Physicians

ISSUED MONTHLY BY THE NATIONAL TUBERCULOSIS ASSOCIATION

THE TREATMENT OF TUBERCULOUS LYMPHADENITIS

A Report by the Comm. on Therapy, American-Trudeau Society, The American Review of Tuberculosis, November, 1954.

The treatment of tuberculous lymphadenitis has received little study since the introduction of specific antimicrobial therapy, as compared with the treatment of pulmonary tuberculosis and of other forms of extrapulmonary tuberculosis. This comparative neglect probably results from the relative infrequence of tuberculosis of the lymph nodes as a presenting manifestation of tuberculosis; and from the widespread impression that when it does so present itself, especially as an apparently localized infection of superficial nodes, it is less serious than most other forms of tuberculosis in the human.

As a consequence, the recent literature concerning the treatment of tubercular lymphadenitis is sparse, especially with regard to the results of antimicrobial therapy. Not only is there no consensus regarding the optimum treatment, but there is scarcely any formulated opinion except that of surgeons and radiologists, who are concerned primarily with the local aspects of treatment by excision or by roentgen irradiation. A recent analysis, however, of all the patients with tuberculosis of the superficial lymph nodes discharged from the Toronto Hospital for Tuberculosis in the twenty-year period 1932-1952 indicates that this is uncommonly a localized form of tuberculosis and no longer predominantly a disease of childhood, which it was earlier, when the excisional treatment of cervical lymph node tuberculosis was perfected. The principle of the complete removal of all involved nodes and cold abscesses has been followed by more recent advocates of the surgical excision of superficial lymph node tuberculosis.

There appears to be no doubt that tuberculosis of the superficial lymph nodes can be effectively treated by excision so far as the local result is concerned. There is also evidence that roentgen irradiation is often locally effective and that, with the lower dosages recently employed, the hazards are not great. Reports of late follow-up results of these forms of treatment are limited and there is little recognition of the possibility that superficial lymph node tuberculosis has become more commonly a manifestation of generalized tuberculosis than it was earlier. Yet in the Toronto Hospital series 88 per cent of the patients had associated tuberculosis elsewhere in the body, most commonly in the lungs and in the bones and joints.

Both the surgical and the irradiation treatments are concerned principally with cervical lymph node tuberculosis and are predicated on the conception that tuberculosis of these lymph nodes is usually a localized form of tuberculosis, of which the portal of entry is the oro-pharynx. Tuberculosis of the tonsils, either from primary or reinfection, is held in this view to be commonly associated with or, indeed responsible for the cervical lymph node tuberculosis. Pathologic evidence that this is now frequently the case is lacking. On the contrary, there is much to suggest that cervical, no less than axillary, intrathoracic, or abdominal lymph node tuberculosis is most often a manifestation of generalized tuberculous infection.

Regardless of whether or not cervical lymph node tuberculosis is often associated with tuberculosis of the tonsil, there is little reason to think that it is frequently caused by infection with tubercle bacilli of bovine origin. Even in 1910 careful studies by Park and Krumwiede showed that infection with tubercle bacilli of human origin predominated except in the age group of less than five years.

The available literature concerning the effect of antimicrobial therapy indicates merely: (1) that tuberculous lymphadenitis does tend to regress under such therapy, although often very slowly; and (2) that short-term, (up to 120 days) therapy is followed frequently by local relapse or the development of active foci elsewhere. The published reports relate almost exclusively to streptomycin or streptomycin-PAS. Very few reports are available regarding long-term therapy, and even fewer regarding isoniazid therapy in this form of tuberculosis.

In view of the paucity of information regarding presently available forms of antimicrobial therapy, the Committee attempted to collect the experience of its own members and of others.

The practice and experience of individual hospitals in the Veterans Administration were polled by the Committee thus adding greatly to the volume of clinical material which could be considered.

The variability in treatment was so great that no statistical analysis of results could be attempted. The practice varied from the one extreme of surgical excision or roentgen irradiation with no concomitant antimicrobial therapy to the other extreme of long-term antimicrobial or simple rest treatment with no local treatment, except in exceptional circumstances. Those hospitals which employed long-term chemotherapy were satisfied with the effect on the lymph nodes themselves and usually reported a favorable result during the maintenance of therapy. No significant data on the incidence of post-treatment relapse were accumulated. The longer that excision of superficial lymph nodes was deferred, the less frequently was it considered necessary. Sinuses usually healed, and cold abscesses regressed, although frequently with the aid of needle aspirin. No comparisons were possible between isoniazid and streptomycin-PAS since, when isoniazid was used, it was usually in combination with other drugs. One observation of special interest is that even lymph nodes which break down or first appear during antimicrobial therapy usually regress satisfactorily if the therapy is continued unchanged. This has been noted both under combined therapy and under isoniazid as single-drug therapy.

The consensus of the Committee, based on the literature and the unpublished experience which was reviewed, is that antimicrobial therapy is indicated in virtually all instances of active tuberculous lymphadenitis, as in other clinical forms of tuberculosis. The evidence indicates, however, that short-term therapy is not adequate and that long-term therapy is not yet established as independently capable of permanently arresting the disease in most instances. The extent to which excisional surgery roentgen irradiation, and prolonged rest therapy are needed is as yet entirely undetermined. There is much to suggest that the management of lymph node tuberculosis simply as a local disease process without systemic treatment is rarely, if ever, justified at the present time. The importance of rest and sanatorium treatment should not be discounted, especially in early cases.

Obviously, there is need for more information, particularly of statistically significant numbers of a considerable number of years. This form of tuberculosis is sufficiently important that its special problems merit particular study, and sufficiently prevalent that such study is practicable. Prepared for the Committee on Therapy, American Trudeau Society, by Carl Muschenheim, M.D., New York Hospital - Cornell Medical Center.

Obituary

TURNER, WYLIE E., SR., 78, of Piggott, died February 10 at his home, of a heart attack.

He was a graduate of the University of Tennessee in Memphis, and practiced medicine in Northeast Arkansas from that time until his death. For many years he was an active member of his county, and state medical societies, and various organizations of his community and the Methodist Church of Piggott.

Survivors include his wife, Mrs. Cora Moore Turner, seven children and 17 grandchildren. Three of his sons are physicians.

Burial services were conducted at the First Methodist Church of Piggott, and burial in the Piggott cemetery.

COMING EVENTS

ARKANSAS MEDICAL SOCIETY

Hot Springs, May 30-June 1, 1955

ARKANSAS ACADEMY OF GENERAL PRACTICE

Hot Springs May 30, 1955

Proceedings of Societies

The Journal congratulates Charles R. Henry on his reappointment to the A.M.A.'s Council on Rural Health.

Washington County heard Davis W. Goldstein, M. C. Wilson, Fred Krock, and Harley C. Darnell, all of Fort Smith, at their March 1st meeting in Fayetteville, held under the auspices of the Committee on Cancer Control of the Arkansas Medical Society. Approximately 30 physicians were present.

Maybe we are getting away ahead of ourselves, but the Pan-American Medical Association with offices at 745 Fifth Avenue, New York 22, N. Y., are announcing their Association Congress for Mexico City, March 25-31, 1957. That gives us time to practice on our Spanish.

Allergists Annual Meeting

The Eleventh Annual Congress and Graduate Instructional Course in Allergy of The American College of Allergists will be held at the Morrison Hotel in Chicago, Illinois, April 25 through the 30th. Any member in good standing of his local county medical society is cordially invited to attend. Further details and the program may be obtained by writing American College of Allergists, La Salle Medical Building, Minneapolis 2, Minnesota.

The Ouachita County Medical Society had speakers Henry Hollenberg, and Alfred Kahn, Jr., both of Little Rock, as their guests February 3rd. On March 3, they heard Paul L. Mahoney and Carl Rosenbaum, also of Little Rock.

The Craighead-Poinsett County Medical Society met March 2nd in Jonesboro.

Malcolm O. Peeler, J. H. McCurry, and Joe Verser were elected as delegates to the state meeting, with John T. Gray and R. C. Hooper to serve as alternates.

The program was as follows: "Treatment of Arthritis With Testoxsterone," John D. Ashley, Jr., Newport, and "The Acute Abdomen," M. C. Hawkins, Jr., Searcy.

Contributors to the American Medical Education Foundation from the State of Arkansas during the month of January, 1955: Jessie Cavener, Little Rock, and Edwin F. Gray, Little Rock.

The Pope Yell County Medical Society met at St. Mary's Hospital in Russellville Wednesday, March 9th, 1955, at 7:30 P. M.

A. M. Washburn of Little Rock spoke on 'Prophylaxosis of Poliomyelitis."

Cyrus P. Klein, Texarkana, is councilor, and Charles Anderson, Pine Bluff, is vice-councilor to the American College of Radiology for 1955.

The Arkansas State Medical Assistants Society Convention will be held on May 28th and 29th in Hot Springs at the Arlington Hotel. Plans for the Convention are being made by Miss Pauline Freeman, Convention Chairman, of Hot Springs.

This meeting is immediately proceeding the meeting of the Arkansas State Medical Society. It is urged that each Physician inform his assistant of the convention and aid them in attendance and in joining this fine group.

ARKANSAS RADIOLOGICAL SOCIETY

The Arkansas Radiological Society met at St. Vincent's Infirmary, Little Rock, March 11, 1955, in a special called meeting by President George Burton.

Notice was given of a refresher course for X-ray technicians, to be given at the Albert Pike Hotel, Little Rock, May 6 and 7, 1955, sponsored by the Arkansas Society of X-ray Technicians, and members were asked to encourage all X-ray technicians to attend this course, and to support in general the work of the Arkansas Society of X-ray Technicians.

Dr. Burton led discussion of a plan to approach the House of Delegates of the Arkansas Medical Society in annual meet, 1955, to approve the formation of a Section of Radiology in the Society, with full program participation as a Section in future annual meetings of the Society. The group gave general approval to the plan.

An announcement was made that some of the residents of Radiology at the U of A might be available for locum tenens work in private offices during summer, as their own schedule permits. Requests for such service should be sent to Dr. Kathleen Egner, Radiology Dept. Medical School, for consideration and approval. A salary of $200 per week, plus expenses, was suggested for such service.

Joe Norton, Secretary.

Personal and News Items

In attendance at the 10th Annual Rural Health Conference, held in Milwaukee February 24th through 26th, were: Ben Saltzman, Mrs. Mason G. Lawson, Mr. Waldo Frasier, Mr. Joe Hunnicutt, Mrs. Wilkie, Miss Helen Robinson, Mr. Bohan, and Charles R. Henry.

Howard A. Dishongh, Little Rock, spent February 15 in Kansas City discussing plans for the Annual Conference and Seminar of the National Coroners Association to be held there next August.

James L. Smith, Little Rock, ophthalmologist, has moved to his new offices at 623 Woodlawn.

Joe H. Poff, Caraway, reported for Army Duty April 4 at Brooke Army Medical Center in San Antonio.

Joe Verser, Harrisburg, was installed as President of the Mid-South Postgraduate Medical Assembly in February. Milton John, Stuttgart, was elected Vice-President for Arkansas.

Horace R. Murphy is now doing Orthopedics in Little Rock in association with Kenneth G. Jones.

Calvin J. Dillaha of Little Rock, was guest speaker of the joint meeting of Dallas and Ft. Worth Dermatologic Society on February 17, in Dallas, Texas.

Texarkana physicians subscribed more than $50,000 to the new Texarkana Hospital in the first week's drive for funds during February.

Joe Verser, Harrisburg, Secretary of State Medical Board, attended the Federation of State Medical Boards in Chicago on February 4, where Mack H. Crabb, Fort Worth, was inaugurated its president.

S. W. Chambers has moved from Mountain Grove, Missouri, and opened offices in Mountain Home, Arkansas.

Orval Riggs, Walnut Ridge, was host of the Lawrence County Medical Society for its February meeting.

Joe Norton, Little Rock, is chairman of the Council of the Presbyterian Church in Arkansas, and will attend the General Assembly of that body in Richmond, Va., in June.

Governor Orval Faubus has named several physicians to various boards in the state. Ralph Crigler, Fort Smith, to the Board of Trustees of the State Sanatorium, John W. Cole, Malvern, to the State Board of Education, and Preston L. Hathcock, Fayetteville, to the Board of Trustees of the University.

Joe G. Ghelton, Jr., is president of the Ashdown Lions Club. He recently addressed the Rotarians of that city on "Medical and Hospital Care in Your Community."

J. J. Monfort, Batesville, secretary of the Arkansas Medical Society, addressed the Baxter County Medical Society in Mountain Home for their February meeting.

John Ashby, Benton, is President of the Saline County Medical Society for the coming year.

Katharine Dodd, Little Rock, has accepted a place on the program of the Texas Academy of General Practice meeting in Fort Worth next September 19-21, 1955.

James M. Kolb, Clarksville, was elected Vice-President of the Arkansas Valley Hereford Association at its Board meeting in Russellville, January 6.

Thomas E. Burrow has returned from duty with the Navy, and has opened his office in Little Rock for the Practice of Urology.

Brooks R. Teeter, Russellville, is new Chief of Staff at St. Mary's Hospital. Vice-Chief is Lewis Webb. Dardanelle, and Secretary is Martin Heidgen, Russellville.

Paul Schaefer, Executive Secretary, addressed the Sebastian County Society Medical Auxiliary at its February meeting in Fort Smith.

Louis Hundley, Pine Bluff, is District Governor for Rotary.

J. W. Walker, Tuckerman, is opening an office at Swifton for evening practice for three days each week.

Ruth Ellis Lesh, Fayetteville, addressed the Bentonville Business and Professional Women's Club at this meeting February 17.

F. W. Smith opened an office in Gurdon in February. He is affiliated with the Dierks Employees Medical and Hospital Association, and has been in Arkansas since 1953.

Alfred Kahn, Jr., and John Fulmer, both of Little Rock, presented a case of "Acrocephalosyndactylism" in the March 10 New England Journal of Medicine.

Milford O. Rouse, Dallas, addressed the Bowie-Miller Counties Medical Society on March 10. Rouse is Chairman of the Council of the Southern Medical Association.

W. L. Steele has joined Sam B. Thompson, and John D. Christian in the Practice of Orthopedics in Little Rock.

C. E. Etheridge, Morrilton, has closed his office for a year's rest, which he will spend at his boyhood home at Tuscaloosa, Alabama.

John W. Morris, McCrory, celebrated his 80th birthday February 6. He has practiced in his county since 1900.

William M. Parker, DeWitt, has moved offices to Little Rock.

Texarkana is planning a new Memorial Hospital of 100 beds, estimated at a cost of $1,500,000.

Friday, April 8, was "Dr. Donaldson Day" in two counties in Northwest Arkansas, honoring C. W. Donaldson, Green Forest.

WOMAN'S AUXILIARY

The Jefferson County Medical Auxiliary's ninth annual Benefit Style Show and Tea was a huge success. At the last count they had a net balance of $949.93. The President, Mrs. Ross Maynard, announced that Mrs. W. J. Wilkins and Mrs. Clyde Hart Jr. were chairmen of the show-tea. All proceeds go toward the Davis Hospital Charity Fund established in 1951 by the auxiliary. The fund is for the benefit of any resident of Jefferson County in need of hospitalization who has no source of financial help. The physicians donate their services. The fund is maintained by contributions, memorials and the proceeds from the annual fashion show.

On March 7, a luncheon was held for members of the Women's Auxiliary to the Jefferson County Medical Society at the Davis Hospital with R. C. Warren, hospital administrator welcoming the group. A business meeting was conducted by Mrs. Ross Maynard, president. New officers were announced by Mrs. Clyde Hart, Jr., nominating committee chairman as follows: Mrs. W. T. Lowe, president; Mrs. W. J. Wilkins, Jr., president-elect; Mrs. Arthur Fowler, Jr., vice-president; Mrs. Ralph Wooley, secretary; Mrs. T. E. Townsend, treasurer; Mrs. O. C. Raney, publicity secretary; Mrs. W. H. Bruce, historian; and Mrs. Ross Maynard, parliamentarian. Mrs. Dorothy Myers, assistant to the Dean for Social Service of the University of Arkansas Medical School, was guest speaker. She reported the results of a recent survey in Arkansas concerning the state medical center and its services. Problems of the center and possible solutions were discussed. Medical experimental work in Perry County financed by Winthrop Rockefeller was described by speakers.

Mrs. E. L. Hutchinson,
Jefferson County.

State Public Relations Chairman, Hrs. Howard Stern of Pine Bluff, writes that the Woman's Auxiliary to the A.M.A. requests that each of you offer fullest assistance to your local Jaycees in observing Community Health Week, March 21-27. The theme will be "Know Your Community Health Resources." Mrs. Stern suggests that you contact the President of the Jaycee in your county and offer your services. The Jaycee Community Health Week Program provides an excellent opportunity for the Medical Auxiliary

to work with an organization whose accomplishments in the field of Community Service are so well known to each of us.

Excerpts from the President's News Letter of the Woman's Auxiliary to the Southern Medical Association, Mrs. Louis Hundley of Pine Bluff:

March 30 is Doctors' Day and 100 per cent observance is urged. Let your councilor from Arkansas know in detail your plans for Doctors' Day, the Councilor to Southern being your state President, Mrs. Hoyt Choate. The true object of the observance is to pay tribute and focus public attention on the real physician and his endless service in his community. A membership committee is being set up in each state to work with a corresponding committee of doctors to help tell about Southern Medical Association and its Auxiliary. Mrs. Jack W. Kennedy of Arkadelphia, Ark. is our Publicity Chairman this year. She is preparing for each State auxiliary publication some pertinent facts about the Southern Medical Association and its Auxiliary. Mrs. Hundley states by sharing our achievements with others we can accomplish much more for the medical profession and the Auxiliaries in the South. Please send her notes about your outstanding accomplishments for the next copy of her Newsletter. Notes about your travels, new babies, grandchildren, and all the events that highlight life in the South.

Southwest District Regional Meeting was held on Feb. 8th, 1955, at Arkadelphia. The following people met at the home of Mrs. Jack Kennedy, First Vice-President of the Woman's Auxiliary to the Arkansas Medical Society: Mrs. P. R. Anderson, Mrs. David Luck, Mrs. Joe Reid, Mrs. Lewis Tilley and Mrs. Wallis Ross, President of Clark County Auxiliary, all of Arkadelphia; Mrs. N. B. Burch and Mrs. Cecil Parkerson, President of Garland County Auxiliary, both of Hot Springs; Mrs. R. C. Dickinson of Horatio; President of Columbia Medical Auxiliary, Mrs. Charles Weber, and Mrs. E. G. Burt, both of Magnolia; Mrs. J. E. M. Taylor of Sparkman; Mrs. Howard Stern of Pine Bluff; Mrs. Gordon Oates, Mrs. Eugene Crawley of Little Rock; President of Union County Medical Auxiliary, Mrs. Sam Jameson had Mrs. C. D. Cyphers and Mrs. Frank Thibault with her from El Dorado; President of Hempstead County, Mrs. George Wright, had Mrs. Wayne Lafferty with her, both from Hope. Honored guests were: President-elect of the Woman's Auxiliary to the American Medical Association, Mrs. Mason Lawson of Little Rock; President of the Woman's Auxiliary to the Southern Medical Association, Mrs. Louis Hundley of Pine Bluff; and the President of the Woman's Auxiliary to the Arkansas Medical Society, Mrs. Hoyt Choate of Little Rock. Mrs. Hoyt Choate talked on Mental Health and Medical Legislation. Reports were made by the Funds Coordinator, Mrs. Gordon Oates; Mrs. R. C. Dickinson, American Medical Education Foundation Chairman; Mrs. Eugene Crawley, Nurse Recruitment Chairman, emphasized the importance of the Future Nurses Clubs; Mrs. Thibault talked on Bulletin and Today's Health and announced that Sevier-Polk County is leading the nation in Today's Health Subscriptions. Mrs. Howard Stern made a talk on Public Relations and Health Education. She displayed an exhibit table and explained that material thereon. She also reported on the progress of her work on the survey of Health Agencies and Health services, and she was praised publicly before the whole group for the excellent work she had done. Mrs. Mason Lawson, Chairman of Cancer Control, talked on the Cancer Commission, and talked about some of her plans for this next year as President of the Woman's Auxiliary to the A.M.A. Mrs. Louis Hundley, President of the Woman's Auxiliary to the Southern Medical Association issued an invitation for everyone to attend the annual meeting of Southern on November 14th to 17th in Houston, Texas. She also suggested that the auxiliaries do something constructive in the way of a gift to the community as a tribute to the doctors on Doctors' Day intsead of so much entertainment; also she asked that the county auxiliaries make suggestions to Southern Auxiliary for some worthwhile method of using the money in the Jane Todd Crawford Fund. There will be some decision made at the November meeting.

Announcement was made of the Rural Health Conference to be held in Little Rock at the Marion Hotel, on June 28th and 29th.

The Clark County Medical Auxiliary did a wonderful job of handling this Regional meeting, with Mrs. Jack Kennedy presiding at the business meeting. Luncheon was served at Henderson State Teachers College. Vote of thanks to Mrs. Kennedy and the members of the Clark County Medical Auxiliary.

Mrs. Gordon Oates,
State Publicity Chairman.

BOOK REVIEWS

Reactions With Drug Therapy: Harry L. Alexander, M.D. Emeritus Professor of Clinical Medicine, Washington University Medical School, St. Louis. January, 1955. PP. 301. Illustrated. $7.50. W. B. Saunders Co., Philadelphia.

The meticulous care which has been put into this reference work is apparent in even the first few chapters. It tends at times ,to be ponderous, but it does achieve a wealth of information on the various reactions of drugs in use today, and it is available without too much wasted space. The Table of Contents is quite complete, and the busy physician can put a finger on that portion in which he seeks information without prodding through a lot of non-essentials. This is considered an important item.

One point emphasized in the texts that is worth remembering is the frequence of fever in all allergic manifestations. In most allergic states it is definitely close to the top of the list of symptoms, and is second only to urticaria in its frequency. This fact is often overlooked by a busy clinitian, and a careful observer of the temperature may warn an attendant when there is danger of further trouble. The references are extensive, the index is complete.

Public Relations in Medical Practice: James E. Bryan Administrator Medical-Surgical Plan of New Jersey. Foreword by Louis H. Bauer, Past-President, American Medical Association. 1954. PP. 301. $5.00. Williams & Wilkins Company, Baltimore.

There are three people connected with any man's practice that should read this book. First, the Doctor, then his spouse, and last, his receptionist. Perhaps there should be added to this list his office nurse, but it is quite likely that these discerning individuals already are aware of the slight deficiencies in the public relations of the other three, and are too loyal to talk about it, or even admit it.

The author has been closely associated with physicians from the day of his birth, and is still far enough away from them to view their foiables, and their strength. A gifted writer, he is clear, his meaning unmistakable, and his advice, while kind, and without dogmatism, is direct from the shoulder. He points out our weaknesses, and suggests a remedy. The book is literature. My office girl gets it next.

U. C. MEDICAL CENTER LIBRARY
JUN 1 1955
San Francisco, 22

THE MAY 1955

JOURNAL OF THE ARKANSAS MEDICAL SOCIETY

VOL. LI No. 12

FORT SMITH, ARKANSAS

79th ANNUAL SESSION ARKANSAS MEDICAL SOCIETY
ARLINGTON HOTEL — HOT SPRINGS — MAY 30-31 - JUNE 1

consider
ILOTYCIN
(ERYTHROMYCIN, LILLY)
FIRST

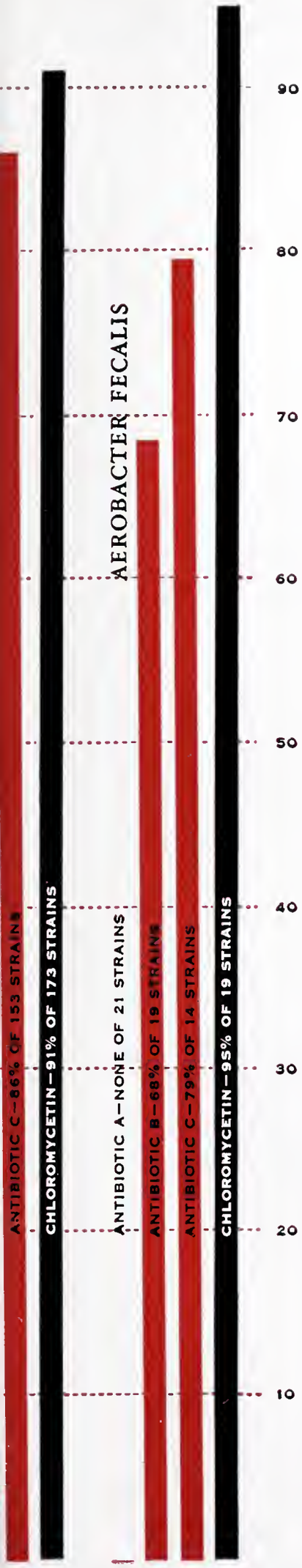
wide clinical range:
80 percent of all
bacterial infections
and 96 percent of all
acute bacterial
respiratory infections
respond readily

notably safe, well tolerated

Lilly

PER CENT SENSITIVITY
HEMOLYTIC MICROCOCCUS AUREUS
ANTIBIOTIC A—57% OF 768 STRAINS
ANTIBIOTIC B—67% OF 752 STRAINS
ANTIBIOTIC C—72% OF 729 STRAINS
CHLOROMYCETIN—74% OF 776 STRAINS
NONHEMOLYTIC MICROCOCCUS AUREUS
ANTIBIOTIC A—57% OF 415 STRAINS
ANTIBIOTIC B—63% OF 405 STRAINS
ANTIBIOTIC C—69% OF 363 STRAINS
CHLOROMYCETIN—89% OF 418 STRAINS
HEMOLYTIC STREPTOCOCCUS
ANTIBIOTIC A—86% OF 197 STRAINS
ANTIBIOTIC B—98% OF 192 STRAINS
ANTIBIOTIC C—92% OF 179 STRAINS
CHLOROMYCETIN—97% OF 179 STRAINS
NONHEMOLYTIC STREPTOCOCCUS
ANTIBIOTIC A—63% OF 141 STRAINS
ANTIBIOTIC B—74% OF 132 STRAINS
ANTIBIOTIC C—83% OF 109 STRAINS
CHLOROMYCETIN—92% OF 141 STRAINS
STREPTOCOCCUS VIRIDANS
ANTIBIOTIC A—80% OF 50 STRAINS
ANTIBIOTIC B—52% OF 50 STRAINS
ANTIBIOTIC C—95% OF 42 STRAINS
CHLOROMYCETIN—100% OF 58 STRAINS
ESCHERICHIA COLI
ANTIBIOTIC A—NONE OF 478 STRAINS
ANTIBIOTIC B—20% OF 575 STRAINS
ANTIBIOTIC C—92% OF 535 STRAINS
CHLOROMYCETIN—94% OF 586 STRAINS
ANTIBIOTIC A—NONE OF 506 STRAINS
ANTIBIOTIC B—17% OF 488 STRAINS

sensitivity of common pathogens to CHLOROMYCETIN and three other major antibiotic agents



more effective against more strains...

Chloromycetin®

for today's problem pathogens

Because of the increasing emergence of pathogenic strains resistant to commonly used antibiotics, judicious selection of the most effective agent is essential to successful therapy. In vitro sensitivity studies serve as a valuable guide to the antibiotic most likely to be most effective. Both clinical experience and sensitivity studies indicate the greater antibacterial efficacy of CHLOROMYCETIN (chloramphenicol, Parke-Davis) in the treatment of many common infections.

CHLOROMYCETIN is a potent therapeutic agent and, because certain blood dyscrasias have been associated with its administration, it should not be used indiscriminately or for minor infections. Furthermore, as with certain other drugs, adequate blood studies should be made when the patient requires prolonged or intermittent therapy.

Adapted from Altemeier, W. A.; Culbertson, W. R.; Sherman, R.; Cole, W.; Elstun, W., & Fultz, C. T.: *J.A.M.A.* 157:305 (Jan. 22) 1955.

MEDICAMENTA VERA

Parke, Davis & Company
DETROIT, MICHIGAN

THE

Journal

OF THE

Arkansas Medical Society

Owned by
THE ARKANSAS MEDICAL SOCIETY
And Published Under Direction of the Council

FOUNT RICHARDSON, M.D., Editor
316 West Dickson Street Fayetteville, Arkansas
MR. PAUL C. SCHAEFER, Business Manager
215 Kelley Bldg. Fort Smith, Arkansas
LITTLE ROCK BUSINESS OFFICE
114 E. 2nd St. Little Rock, Arkansas

The Advertising policy of this JOURNAL *is governed by the rules of the Council on Pharmacy and Chemistry of the American Medical Association.*

EXCLUSIVE PUBLICATION—Articles are accepted for publication on the conditions that they are contributed solely to this JOURNAL.

COPYRIGHT, 1955—By The JOURNAL *of the Arkansas Medical Society.*

NEWS—Our readers are requested to send in items of news, also marked copies of newspapers containing matter of interest to the membership.

OFFICERS OF THE ARKANSAS MEDICAL SOCIETY

W. R. BROOKSHER, President....Fort Smith
L. H. McDANIEL, President-Elect....Tyronza
T. P. FOLTZ, First Vice-President....Fort Smith
ELDON FAIRLEY, Second Vice-President....Wilson
R. H. WHITEHEAD, SR., Third Vice-President....DeWitt
J. J. MONFORT, Secretary....Batesville
DANIEL H. AUTRY, Treasurer....Little Rock
T. DUEL BROWN, Speaker, House of Delegates....Little Rock
C. C. LONG, Vice-Speaker....Ozark
MR. PAUL C. SCHAEFER, Executive Secretary
215 Kelley Bldg., Fort Smith

COUNCILORS

First District—JOE VERSER....Harrisburg
Second District—HUGH R. EDWARDS....Searcy
Third District—J. MAX ROY....Forrest City
Fourth District—L. K. HUNDLEY, Chairman....Pine Bluff
Fifth District—D. E. WHITE....El Dorado
Sixth District—HARRY E. MURRY....Texarkana
Seventh District—H. KING WADE, JR....Hot Springs
Eighth District—H. ELVIN SHUFFIELD....Little Rock
Ninth District—FOUNT RICHARDSON....Fayetteville
Tenth District—J. M. KOLB....Clarksville

VICE-COUNCILORS

First District—WAYNE WORKMAN....Blytheville
Second District—JOHN SNEED....Conway
Third District—J. P. WILLIAMS, JR....Brinkley
Fourth District—H. W. THOMAS....Dermott
Fifth District—GEORGE BURTON....El Dorado
Sixth District—CHARLES YARBOROUGH....Texarkana
Seventh District—RANDOLPH ELLIS....Malvern
Eighth District—ROBERT D. JONES....Little Rock
Ninth District—LEE A. DEAN....Rogers
Tenth District—LOUIE A. WHITTAKER....Fort Smith

Notice on Form 3578-P to be sent to the Arkansas Medical Society, 215 Kelley Building, Fort Smith, Arkansas. Published monthly under direction of the Council, Arkansas Medical Society. Vol. LI, No. 12. Subscription $3.00 a year. Single copies 50 cents. Entered as a second class matter, May 1, 1955, at the post office at Little Rock, Arkansas, under the Act of Congress of March, 1879. Acceptance for mailing at special rate of postage provided for in Section 1103, Act of October 3, 1917, authorized August 1, 1918.

• SPECIAL FEATURES

Committee on Cancer Control 281
Cerebral Angiography 282
Case Report 285
Convocation Address 287
Report of Medical Education Committee 290

• FEATURES

Editorial 291
Public Relations 291
Arkansas Traveling 291
Obituary 292
Journal Index 294
Tuberculosis Abstracts 296
Proceedings of Societies 297
Personal and News Items 298
Woman's Auxiliary 299
Book Reviews 300

The JOURNAL
OF THE ARKANSAS MEDICAL SOCIETY
PUBLISHED MONTHLY UNDER DIRECTION OF THE COUNCIL

Vol. LI MAY, 1955 No. 12

Committee on Cancer Control

C. A. ARCHER, M.D., Chairman

THE ROUTINE EXAMINATION IN DETECTION OF CANCER

Danger signs suggestive of the presence of cancer are well-known but there is, as yet, no screening plan whereby cancer may be more readily diagnosed. Early diagnosis depends upon the care with which the physician conducts the detection, or routine physical, examination. For the proper conduct of such an examination the physician must be convinced that his efforts may have some success in the early recognition of malignancy.

It has been estimated that a large percentage of all cancers may be detected by a routine, carefully performed physical examination. All available diagnostic measures should be employed but attention to facts which may be determined by the palpating finger and the seeing eye will result in the earlier detection of many unsuspected lesions.

This complete examination can be made by any physician whose office has ordinary equipment.

The practicing physician can and should make his office a cancer detection center.

CEREBRAL ANGIOGRAPHY

ROBERT WATSON, M.D., AND JOHN H. ADAMETZ, M.D.

It was only a few years back that aneurysms of the cerebral circulation, or arteriovenous malformations of the brain were looked upon as oddities, exposed most frequently at the time of autopsy. These findings were accepted with a feeling of passive resignation, and recognized so late as to offer only consolation to a bereaved family, and no benefit whatever to the possessor.

Repeated episodes of spontaneous subarachnoid hemorrhage, if recognized, were likewise looked upon with a feeling of fateful acceptance, and a hope that the inevitable recurrence would be either so long delayed, or of a character sufficiently mild as to permit survival, at least for awhile longer. Recurrent episodes of transient hemiplegia, or recurrent focal convulsions were likewise frequently accepted with this same attitude of hopelessness.

However, in 1927 Egaz Moniz,[1] a Portuguese neurologist, reported a procedure in which radiopaque dye could be injected within the carotid artery in the neck to permit X-ray visualization of the intracranial vascular circulation. This commendable work permitted a more favorable outlook and understanding concerning these lesions which previously had been looked upon with such a hopeless attitude.

Failure to find a satisfactory media for injection delayed the immediate acceptance and universal application of this procedure. However, continued advancements in the search for a satisfactory injectable media, and the development of mechanical rapidly changing seriographic X-ray machines, together with advancing surgical techniques, have in the past few years converted these supposedly rare and surgically unapproachable oddities into well established and readily recognized pathological entities. Now many of these lesions can be approached with a knowledge and understanding such as to offer to the patient a likelihood of remedy, relief, and justified hope of a full life expectancy.

The techniques of these procedures have now become universally standardized and accepted, and a detailed repetition of procedure is not particularly adaptable to this paper.

Indications and Use

The procedure of cerebral angiography can be gainfully employed in the study of the majority of gross pathological changes within the cranial cavity. Although, of course, not to be used indiscriminately or inadvisedly, it is less dangerous, and far less disturbing to the patient than are some of the other well-established diagnostic procedures in daily use. Advanced cerebral arteriosclerosis, extreme old age, and severe cardio respiratory diseases should be considered as likely contraindications to the use of this diagnostic procedure.[2]

Cerebral angiography is indicated in instances of spontaneous subarachnoid hemorrhage, either initial or recurrent, suspected intracranial aneurysms, suspected cerebrovascular malformations, angiomatous tumors, suspected brain tumors, suspected subdural hematomas, or even recurrent convlusive disorders of a focal character.

Proper technique may demonstrate the character and extent of vaguely suspected intracranial aneurysms or other vascular malformations, and in some instances may demonstrate the unsuspected multiple existence of such. X-ray demonstration of distortion and displacement of major cerebral vessels frequently shows with accuracy the presence and location of space-occupying intracranial tumors. Frequently the consistency of the vascular pattern in a tumor mass indicates the probable histology of the tumor. Vascular lesions, earlier assumed to be surgically unapproachable, may, due to demonstration of their arterial supply, be now looked upon with greater courage and understanding, or through these studies a surgeon may, with greater peace of mind, decide against surgical interference.

In many instances repeated episodes of puzzling and unexplained attacks of transient paralysis, disturbances of visual fields, or even transient speech disturbances, when not controlled, may likely lead to irreversible neurological damage, if not death.

The primary purpose of this publication is to call to mind the surprising frequency of cerebral vascular malformations possessing characteristics amenable to surgical benefit. The limited scope of this paper prohibits illustration and discussion of the full field of application for cerebral angiography.

Three illustrative cases of cerebral vascular malformations are presented, two of a favorable and one of an unfavorable nature.

Case I

W. G. B., a nineteen-year-old college student, was admitted to the hospital January 3, 1954, with a chief complaint of the sudden development of left-sided headache twenty-four hours before, not associated with straining or exertion. Twelve hours after onset he experienced one episode of nausea and vomiting, and demonstrated at the time of admission a moderate nominal aphasia. The patient was, at the time of admission to the hospital, mentally clear, alert and cooperative. The vital signs were entirely within normal limits. Ophthalmoscopic examination revealed definite venous engorgement of the retinal veins, but no true papilledema. A right hemianoptic visual field defect was present. There was no facial weakness and no cranial bruit was audible. Grips were excellent, coordinative tests were well performed in all extremities, and the deep tendon reflexes were within normal limits throughout. A spinal puncture revealed a pressure of 200 mm. of water, with no cells, and 37 mgms. per cent protein. Plain X-rays of his skull were entirely negative. In an interval of twelve days the symptoms all subsided and the patient was discharged, with a diagnosis of suspected left temporal intracerebral hemorrhage.

In September of 1954 he was again hospitalized for four days, following a generalized convulsion, not associated with any abnormal neurological findings.

He was re-admitted to the hospital on October 14, 1954, because of a thirty-day story of persistent headaches. Repeated episodes of loss of consciousness had occurred during this thirty-day interval. Once more the retinal veins were engorged, but a true papilledema was not present. Cerebral arteriograms revealed a rather extensive vascular malformation. (Fig. 1.)

This lesion was of a nature that could with safety be ligated and removed. Evidences of previous hemorrhage from the malformation, as suggested in the initial onset of symptoms the preceding January, were found at operation. This patient was discharged on the eighth postoperative day without residual disability, and is now continuing with his college education.

Case II

J. McD., a forty-six-year-old male, was admitted to the hospital in stupor June 30, 1954. History from the family was to the effect that four years earlier this man experienced a sudden onset of headache, followed by nausea and vomiting, and a transient weakness of the left-sided extremities, lasting for several days. These symptoms subsided without residual disability. One year before admission he experienced a sudden severe right-sided headache, lasting for two or three days, but without apparently associated neurological findings. Five days previous to the present hospital admission the patient again experienced sudden severe headaches, later associated with two or three episodes of nausea and vomiting. Coma had persisted for two days previous to admission to the hospital. On examination a definite bilateral papilledema was present, and a faint left hemiparesis was demonstrable. No cranial bruit was heard. Arteriograms demonstrated a vascular malformation. (Fig. 2.)

Fig. 1

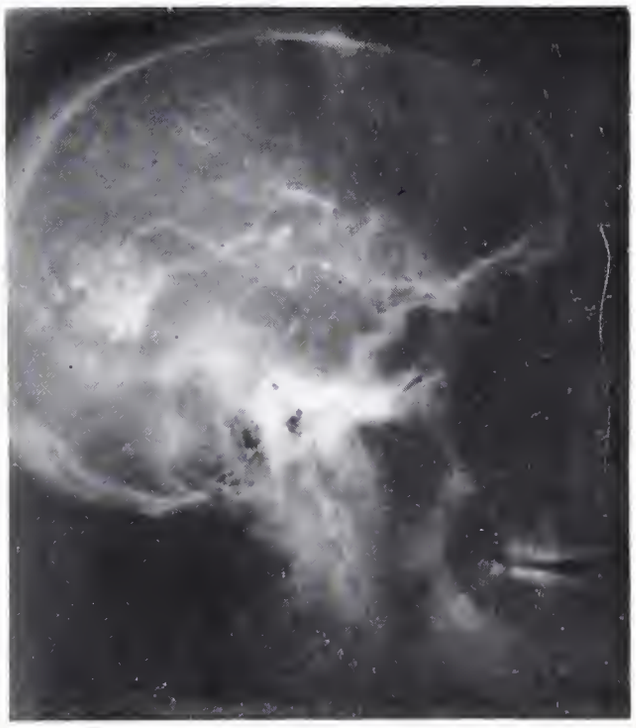


Fig. 2

At operation evidence of relatively recent intracerebral hemorrhage was encountered and removed. Vascular tributaries to this arteriovenous malformation were identified and ligated, and the mass itself was excised. This man was discharged from the hospital on his twelfth postoperative day. He has experienced no further difficulties, and is at present employed at his same work with an oil refinery.

Case III

The third illustration is of a comparable pathological nature, but of a location prohibiting direct surgical attack. The patient was 41 years of age. Fourteen years before the date of this present admission an exploratory left temporal craniotomy had been done elsewhere. The operative record at that time described a normal appearing cortex and vascular distribution over the temporal and parietal area. One year later the left common carotid artery had been ligated in the neck. For five years previous to the present admission a right hemiparesis had prevailed.

Fig. 3

Five days previous to the present hospital admission this patient experienced a sudden abrupt development of severe headache, nausea, vomiting, transient stupor, and progression of the right hemiparesis, to a complete hemiplegia. On admission to the hospital on January 13, 1955, the patient was drowsy, listless and possessed a complete right hemiplegia. A marked papilledema was present. Spinal puncture revealed 300 mm. spinal fluid pressure. The fluid was xanthochromic. Cerebral arteriography (Fig. 3) revealed an extensive cerebral vascular malformation located deep in the insular area in her dominate hemisphere, and because of the location and extent it was judged to be surgically unapproachable. At the time of discharge from the hospital ten days later, the right hemiplegia persisted, but conscious state and speech showed some spontaneous improvement.

Conclusions

A brief description of the indications and application of the technique of cerebral angiography has been given. Three demonstrative cases of cerebral vascular malformation have been shown.

1. Moniz, E.: L'Angiographic Cerebrale. Masson et cie, Paris, 1934.
2. Arteriography in General Hospital Practice (R. C. Moore) Radiology 57: 487-498. Oct. 1951.

PRESIDENTIAL INAUGURAL CEREMONY TO BE BROADCAST

Highlights of the inauguration of Dr. Elmer Hess of Erie, Pa., as 109th president of the American Medical Association will be broadcast nation-wide on Tuesday evening, June 7, during the Association's 104th Annual Meeting. The ceremonies will be held in the Ballroom of Convention Hall at Atlantic City, N. J.

An added attraction will be an address by the celebrated Norman Vincent Peale, D.D., pastor of the Marble Collegiate Church of New York City.

SEX EDUCATION PAMPHLETS AVAILABLE SOON

A new series of sex education pamphlets is in the final production stages by the Joint Committee on Health Problems in Education of the National Education Association and the AMA. Designed primarily for parents, teachers and youth leaders, some of the pamphlets also are suitable for youngsters, and doctors may want to include them in patient education programs.

The five booklets are: (1) "Parents' Privilege"—for parents of pre-school and early school age children; (2) "A Story About You"—for children, ages nine to 12; (3) "Finding Yourself"—for boys and girls, ages 12-15; (4) "Learning About Love"—for both sexes, ages 16-20, and (5) "Facts Aren't Enough"—for adults who have responsibility for children or youths which may create a need for an understanding of sex education.

The booklets are scheduled for release about May 15 and may be obtained from either AMA's Order Department or the NEA headquarters in Washington, D. C. Prices available on request. The Joint Committee is composed of five physicians and five educators representing the sponsoring organizations.

CASE REPORT

Mesenteric Thrombosis; Early Radiographic Sign, With Report of Case

JEFF BAGGETT, Prairie Grove, and H. W. WARD, Fayetteville

Mesenteric Thrombosis; rarely diagnosed preoperatively, simulates other abdominal catastrophes. It is frequently confused with perforated ulcer or appendicitis. Radiographs of the abdomen in a well-advanced case are usually confused with a mechanical obstruction.

Arteries are affected more than the veins, and thrombosis is 40 times more frequent in the superior than in the inferior mesenteric artery. The disease is rare under 40. Many cases run a fairly mild course and weeks may elapse before the existence of such a lesion is suspected.[1] Such may have been the chain of events in the case herein presented. In most cases infarction occurs soon after the occlusion. Fluids and gases then collect in the dilated bowel loop and eventually there is increased activity, which is manifested clinically by profuse diarrhea. As gangrene ensues, the clinical picture is dominated by a rather diffuse peritonitis. Severe pain and a shock-like state are frequent with a rapid and irregular pulse. Yet, despite these symptoms mesenteric thrombosis is rarely recognized prior to surgery.

Case Report

L. C., Case 11187, a 53-year-old white male, entered the hospital with a history of becoming ill one month previously with what he thought was "intestinal flu." At the onset he had noticed abdominal cramps, there was no diarrhea. Symptoms continued and three weeks later he sought medical attention from another physician. Gastro-intestinal series and gall bladder series were obtained. Gastro-intestinal series was negative and the gall bladder series revealed poor visualization of the gall bladder. A repeat gall bladder series was obtained three days prior to admission to the Washington County Hospital, the repeat study utilizing 12 telopaque tablets. Following the ingestion of these tablets patient became nauseated but reported back to his physician the following day for gall bladder films. It was thought at the time that his nausea and distress were due to the gall bladder dye and since he did not appear acutely ill the abdomen was not examined. Films again revealed poor visualization of the gall bladder. Following this examination the patient could not retain anything by mouth, had had no bowel movement nor had he passed gas by rectum. Three days following the second gall bladder series he called a second physician (JB). An enema was prescribed which gave some relief with the return of reddish colored fluid. However, he continued to be nauseated, became distended and vomited greenish material, becoming very weak. The following day he was admitted to the Washington County Hospital.

On admission the patient was acutely ill. The abdomen was markedly distended throughout, with no fluid waves or patterns noted. Tenderness throughout the entire abdomen was present, the tenderness was more marked in right lower quadrant with a positive rebound, and muscle guarding and induration in right lower quadrant. The abdomen was completely silent. There was a palpable mass approximately the size of a grapefruit, firm in consistency in right lower quadrant. The skin was pale, the eyes sunken. Blood pressure was 84/76. The temperature was 100.4°F, rectally.

A film of the abdomen was reported "the appearance of the abdomen suggest complete mechanical small bowel obstruction, the appearance of the right lower quadrant suggest the possibility of a large intraperitoneal abscess, possibly appendiceal in origin, as the etiological factor." Icterus index was 8.2 units. Blood sedimentation was 26 units per hour. RBC 5.20, WBC 10,700. Urinalysis revealed 2 plus albumin.

Clinical impression was appendiceal abscess with mechanical obstruction. Patient prepared for surgery, the objective being to drain the abscess. The abdomen was opened through a right rectus incision, under spinal anesthesia, on the 2nd hospital day. The peritoneum was discolored and inflammatory. As the peritoneum was opened, bloody foul odored fluid was encountered. The small bowel was gangrenous and following the aspiration of fluid in the abdomen about 6 feet of small intestine was delivered. The mesentery was thickened and friable and contained numerous old blood clots. Intestinal clamps were placed on the bowel about 4 inches beyond the gangrenous portion and the affected segment excised. The mesentery was then clamped low and excised with end to end anastomosis of the small bowel then being performed. Two penrose drains were placed in the abdomen,

one in the right colonic gutter, the other in cul de sac. The patient became shocked during surgery, was given blood and stimulants. His post-operative condition was very poor.

The patient's post-operative course was stormy, temperature reaching 104°F, rectally on the 3rd post-operative day, pulse 140, respiration 19. He was treated with Levine tube, continuous suction, achromycin intravenously with feeding, dicrysticin, 1500 cc whole blood together with other supportive treatment. He developed some peristaltic sounds, passed gas from the rectum and the distention decreased. Patient expired on the 7th post-operative day, apparently due to an extension of the mesenteric thrombosis. Permission for autopsy was not obtained.

Radiographic Findings

In this case the film obtained on admission (Figure 1) revealed numerous dilated, gas containing intestinal loops with a soft tissue mass being

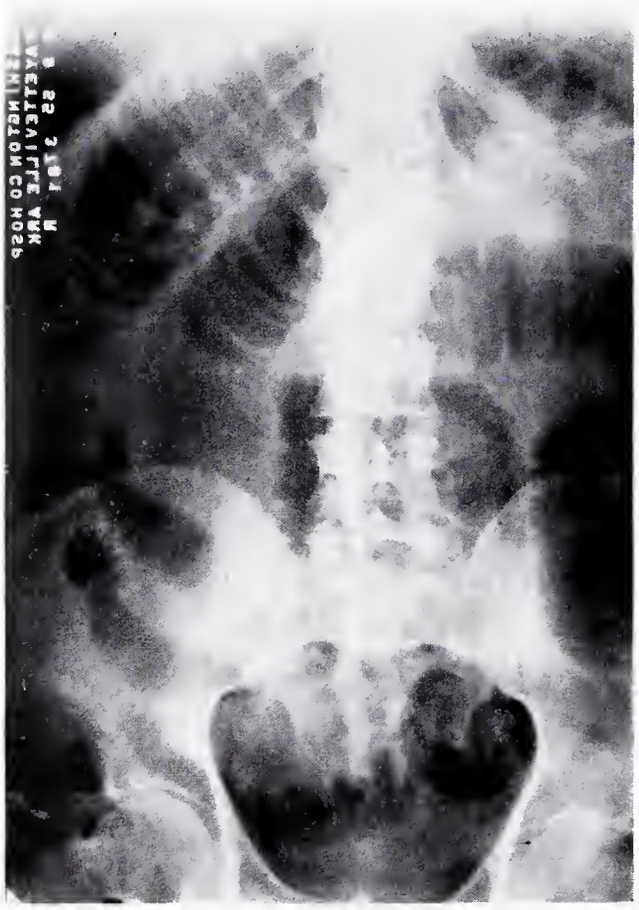


Figure 1—Film of abdomen obtained on admission, soft tissue mass in right lower quadrant, with separated, edematous ileal loops.

suggested in the right lower quadrant apparently separating smooth slightly dilated gas-containing loops.

There was a slight separation of the gas containing loops in the left lower quadrant suggesting the possibility of intra-abdominal fluid. The film was interpreted as representing a complete mechanical obstruction, possibly due to intraperitoneal abscess such as an appendiceal inflammatory mass. In retrospect, in viewing the film there can be demonstrated some thickening of the wall, with thickening of the valvulae conniventes which has been described by Frimann-Dahl as characteristic of mesenteric thrombosis.

In preparing this case for the monthly staff meeting, the patient's films from an outside source were obtained and reviewed. Films of the abdomen, obtained for gall bladder study,

Figure 2—Film obtained 3 days prior to admission. Infarcted segment visualized as thick walled gas containing loop (arrows).

(Figure 2) revealed a single gas containing small intestinal segment with the markedly thickened and edematous wall being apparent as a soft tissue density. This segment measured about 8 cms in length and the wall thickness slightly under 1 cm. This undoubtedly represented the beginning of the mesenteric thrombosis with the involved segment being visualized by virtue of edema and hemorrhage into its walls, of sufficient magnitude to be clearly visible radiographically. This sign has been described previously by other authors.[2]

Summary

An early radiographic sign of mesenteric thrombosis, consisting of soft tissue shadow of an edematous intestinal wall together with a local-

ized gas-containing segment, has been described. Case presented apparently ran a fairly mild course with progressive extension of the infarction prior to and following surgery. The etiology was probably arteriosclerosis.

REFERENCES

1. Frimann-Dahl, J.: Roentgen Examination in Mesenteric Thrombosis, American Journal of Roentgenology. 64:610-616, October, 1950.
2. Cregg, Hugh A., and Smith, Frederick G., Radiographic Demonstration of Localized Mesenteric Thrombosis. Radiology, 61:379-381, September, 1953.

CONVOCATION ADDRESS*

L. H. McDANIEL, Tyronza
President-Elect, Arkansas Medical Society

My Friends—I feel that I can express the same sentiment as did the cow to the milkman on the bitter cold morning — "Thanks for the warm hand." I feel certain after this address that you will never say that our beloved dean deserves the epitaph that was found on the tombstone of a maiden lady in our section which read "She Played Her Game Thru—No Runs, No Hits, No Errors." The good dean has made several runs, many hits and now he is making his first error in choosing me to make his convocation address which I assure you is like a childbirth—easy to conceive but hard to deliver.

You know my young friends a person can almost get a liberal education just walking through the clinics and overhearing the remarks. Why only this morning I heard remarks emitting from Dr. Willis Brown's office evidently from a member of the junior or senior class in obstetrics—who did not see eye to eye with Dr. Brown's grading. I give you my impression — with apologies to Edgar Allen Poe.

"Quoth a junior student sore
I deserved a pass, a four
Will you let me stand it o'er?"

Willis B. Scrowling—"Six, a flunk and nothing more." I guess the old apple polishing still flourishes as it did 30 years ago.

Then outside Dr. Dodd's office listening to the student telling the good doctor that he didn't think he deserved a zero, and the doctor's retort —I don't either but that was the lowest I could give you. Then I went on by Dr. Reece's psychiatry clinic and I believe some of the patients there will soon be transferred to the hill. What a loss of time not sending them out there in the first place.

Enough of this levity—will you not permit me to express my appreciation for the honor of being your convocation speaker. On an occasion such as this I think that sufficient praise and gratitude cannot be bestowed on the full time teachers of medicine who forsake the plaudits of the public, the remunerations that go to leaders and executives, and who have to wait years and years until some of his students are acclaimed the leaders of their field—and then he realizes in his heart that the lessons he had to drum into that students' mind are now paying off rich dividends in satisfaction to the teacher and lasting benefit to society.

May I not quote you a little verse originally written by my late friend, Dr. Jere Crook, of Jackson, Tennessee, past president of the Mid-South Medical Association, past president of the Southern Medical Association, et cetera — I quote:

If with pleasure you are viewing
Any work some one is doing
Tell him now.
Don't withold your approbation
'Til the preacher makes oration
And he lies with snowy lilies on his brow
For no matter how you shout it
He will never know about it
He'll not know how many tear drops you have shed
If you think some praise is due him
Now's the time to slip it to him
For he cannot read his tombstone when he's dead.

I salute the full time professor as the cornerstone and foundation of our medical education—

The good things that are ours today, are ours primarily because some one saw a need, and then took it upon himself to answer that need—and didn't count the cost. To give you only one example, and there are multitudes of them; in the year of 1900 three men went down to the Canal Zone in the hopes that they might discover the cause and the cure of yellow fever which every year claimed thousands of Southern lives. They were men who had every reason not to go, because they had families of their own. They were Dr. Walter Reed—and when you boys and girls go through the Walter Reed Hospital and marvel at the wonders of the place you are only paying tribute to a doctor of medicine who was also a

* Delivered at the Convocation Opening, the University of Arkansas Medical School for the year 1954-1955.

full time teacher of medicine—Dr. Jesse Lazear and Dr. James Carroll. One hot sultry afternoon during the early part of their investigation Dr. Reed said to the other members of the commission. "If the members of this commission are willing to take the first risk, if you are willing to be bitten by mosquitoes who have fed on yellow fever cases — but then he was interrupted by Jesse Lazear who had a wife and 2 small children back home who spoke up and said—"You may count on me, sir. I am ready to be bitten," and Dr. James Carroll who had seven in his family said, "That goes for me too."

On September 19, 1900, Dr. Reed made this entry in his report about Jesse Lazear: "12 o'clock noon, temp. 102.4, pulse 112, eyes injected, face suffused. 6 p.m. temp. 103.8, pulse 106, seven days later on Sept. 26 is this entry. Jesse Lazear died today at 4:05 p.m."

There is a sequel to this story. Just about three months later on New Year's Eve, Dr. Walter Reed, who himself was (ravaged) with fever sat down and wrote a letter to his wife in the United States and he put in that letter this unforgettable sentence "The prayer that has been mine for 20 years, that I might be permitted in some way, or at some time to do something to help alleviate suffering has now been granted." Small wonder that they named that great hospital in his honor.

Enough for the faculty—now for the students—but it has been so aptly said that we continue to be students to the end. Several months ago I gave a series of lectures to the senior class on medical ethics. In fact, I may still be the professor of medical ethics and I will be glad when the dean again schedules my lectures on medical ethics. Possibly sympathy for the students encouraged the dean to eliminate the course. May I not advance a thought today that was developed at length in the lecture course. I wish to tell you that I like to compare the building of a medical life, this project that each one of you are engaged in daily, to the building of a home or a structure that is to be a source of comfort and profit in the future. We tell you that we could obtain the foundation for this building in the teachings to be found in the "Sermon on the Mount," or in other words, in the character that you should have stored up in your soul—irrespective of medicine. We tell you that the roof for this building could be secured in the ideals of Hippocrates, Osler Vinsonhaler and other great souls of medicine. We tell you that the four walls of this building, your medical career if you please, can be found and represented in the way that each one of you fulfill your obligation, first to the patient whose interest is paramount at all times and under all circumstances. Second, to your brother physician who is always your brother and never your competitor, to your community, which includes the economic standards you will provide for your family in that given community and lastly to your own soul, or call it your own conscience, if you please. I say to you—construct this building—your medical career to be exact—along the lines of honor, integrity and efficiency.

The diploma in medicine today means more than a piece of paper or sheepskin which says that its recipient has satisfactorily completed the required number of hours of classroom study, laboratory investigation and clinical practice. Every new doctor of medicine, whether he realizes it or not, receives a priceless heritage. His medical degree is the sum total of all the hard work, intensive study and self-sacrifices of his doctor forbears. He, the young physician, does not have to pay royalty on the patents of medical innovations and discoveries, no matter how much they cost the discoverer in time, hardships and personal sacrifices. They are given to the medical profession and to posterity as freely as the Lord gives us air, water and sunshine. That is the way of medicine; that is the sacred and trusted prestige that has been handed down to us from generation to generation since the days of Hippocrates.

The master-minds of all great physicians and learned scientists are our storehouses of knowledge. We can sit in the laboratories of Pasteur and Koch while they try to unravel the secrets of bacteriology; we can travel to London and watch Lister in his efforts to do aseptic surgery, or Mackenzie and Lewis classify the diseases of the heart; we can travel to that country home near Jefferson, Georgia, and assist Crawford Long, in the first ether anesthetic; we can journey to Cuba and sit outside those screened huts as Gorgas applied the finding of Walter Reed and the yellow fever commission that yellow fever is transmitted by the stegomyia mosquito; we can make Ward walks with Osler and Janeway and learn to diagnose diseases with our God-given senses; we can watch the surgical technic of Deaver, Dacosta, Cushing, Matas, the Mayo's or follow Banting as he pawns his old Ford that he might continue his efforts to produce insulin; and then we can analyze ourselves and wonder what we have added in new thought, new technic, or new discoveries to the science of medicine. Most of us are neither scientists, teachers nor research workers. Yet, there is plenty we can do in zeal-

ously guarding our present system of medicine, and leaving to our medical descendants a profession as honored, as trusted, and as beloved as when we accepted the trust.

I wonder how many of you students have ever heard the story of the Birth of the International Red Cross? Will you please raise your hands? For the benefit of those who have not heard the story of the origin of this great humanitarian system may I not in closing relate it to you?

Ninety-five years ago, at a time that the armies of imperial France and Austria met in the Battle of Solferino, Henri Dunant, a young tourist from the City of Geneva, Switzerland, found himself in that little town on a summer's vacation. As a civilian he naturally sheltered in a cellar in the little town, to emerge only after the din of battle had subsided, to find the town in rubble and thousands upon thousands of wounded and dying soldiers everywhere upon the fields and hills of that section of Northern Italy, with not a single solitary soul to look after their welfare, no one to bind the wounds, to carry water to the thirsty, to alleviate the suffering, for, only some ninety years ago, the world did not have organized medical and nursing services such as we profit by in our day. Young Dunant saw the frightful plight of these helpless men about him (history tells us of 250,000 men that met in the Battle of Solferino, with over 15,000 left wounded in the field).

Dunant, a man of compassion, however, did not remain content in wringing his hands over the suffering and misery around him, he also was a man of action, rushing back to town, he mustered there a band of frightened women and old men and with their help, and with blankets, buckets and sheets, these people returned to the battlefield and under Dunant's direction organized and improvised a nursing service. Tirelessly they worked through days, nights, into many weeks, binding wounds, quenching thirsts, burying the dead. An old ox-cart Dunant found in a barnyard was repaired by him, and this constituted the only ambulance available for these 15,000 wounded soldiers. The church on the hill, a Catholic church, was turned into a field hospital and there the wounded were soon crowding in over the pews, underneath them, under, around and on top the altar, everywhere the work of humanity became evident. Then, in due time, Dunant returned to his home town, Geneva in Switzerland. He had been deeply shaken by the suffering around him and the memory of the battlefield of Solferino preyed on his mind. A year later a book appeared, written by one Henry Dunant of Geneva. Written in his native French language, the "Souvenirs of Solferino" became a best seller. They were not pleasant souvenirs of a tourist or the account of a war correspondent, but the frightful memories of a battlefield, a description of the horrors of modern warfare, the impact of steel against human flesh and particularly a description of the suffering of soldiers neglected and abandoned on the battlefield. Dunant felt that just as he was able to bring help and alleviation of suffering to many at Solferino so by a concerted effort of all warring parties much needless horror could be eliminated in the future. The book was a challenge to mankind, it almost became the voice of conscience of humanity. For Dunant demanded in his book that an organization be formed by the civilized nations of the world, an organization that would take care of soldiers fallen in battle, the disabled and wounded soldiers of **all** armies. He outlined plans for such an organization and then, after publication of his book he followed up the idea through lectures, public appearances and demands to the rulers, the Parliaments and the peoples of the world, challenging, demanding the immediate formation of such an organization to be above narrow national and political interests and ambitions. He visualized a supernational organization of human brotherhood, above all nations, that could take care of soldiers left in battle and could well be carried into the areas of peace to benefit all humanity in times of earthquakes and floods and natural and unnatural disasters. He traveled through many European lands, always challenging and pleading for his idea. In vain, however, for many long and disappointing years, he was ridiculed, the people and their rulers looked upon him always as a subversive. He sacrificed his fortune, his health and almost his sanity in his frantic and sincere crusade on behalf of suffering humanity. Through six weary long years he carried on until finally this persistent and lonely voice of humanity was heard and listened to. And in 1864, Dunant had the unique pleasure and satisfaction of seeing the nations of the world gathering in his home town Geneva, to sign and pledge themselves to his organization, then and there the famed Geneva convention implemented Dunant's organization of mercy and in recognition of the services of this unique Swiss citizen, this persistent Swiss citizen, his own countries national flag, the White Cross on the red field, was simply reversed in colour and thus became the emblem of mercy, the Red

Cross, to be unfurled above the battlefields and above humanity for all time.

That is the story. There is, however, a sequel to it, and not a very happy one. For after the convention of Geneva, Dunant simply disappeared. He might have died for all his contemporaries knew (and even his friends) and no one ever heard of him again. It wasn't until the turning years of this century, and many decades after Solferino, that a Swiss journalist vacationing in a little town in Eastern Switzerland one pleasant spring morning, walking down the cobble-stoned streets, passed a building upon whose steps there sat an old, old man, white flowing beard, threadable clothing, feeble in body and embittered in mind and within a few minutes conversation, that young journalist realized that he was speaking to none other than Henri Dunant—one of the great benefactors of mankind, the founder of the Red Cross, who had become a totally forgotten and impoverished old man. That man who had single-handedly created an organization which in spirit and conception constituted one of the most important steps towards the ultimate goal in humanity's upward surge—had simply become a forgotten man. Of course, a remorseful world soon attempted to remedy a regrettable oversight. The Nobel Peace Prize, the first time bestowed upon anyone, was given to Dunant, monies were collected for him in many parts of the world, yet Dunant would not touch one penny of it, all was turned over by him to his creation, the Red Cross. He died in 1910 in the charity home in Eastern Switzerland in self-imposed poverty.

This man Dunant has since become one of the national heroes of Switzerland, one of the gigantic figures in human history. No monuments have been built to his memory as yet, perhaps that Red Cross in the white field is a great enough monument to his achievement, I cannot conceive of a greater one. This great man, who had sacrificed and done so much, lived selflessly and worked tirelessly for his fellowmen and who at no time presented the world with an expense account or a demand for payment for services rendered, embodies in his life's work and philosophy the noblest aspirations of men of good-will. He expressed his own philosophy a few minutes before his death, when he whispered to his friends gathered about him: "We are in this world to help one another."

My friends, we are in the practice of medicine, we are studying medicine, we are teaching medicine, yes we are in this world to help one another.

Dr. Walter Reed, Dr. Jesse Lazear, Dr. James Carroll, Henry Dunant, each had his own particular conception of values. What is to be your conception of value? I leave the question with you—the answer of which must be answered in the coming years in your scientific, social, and spiritual conduct toward your fellow-man.

REPORT OF THE COMMITTEE ON MEDICAL EDUCATION OF THE ARKANSAS MEDICAL SOCIETY

The Committee on Medical Education, composed of John Smith, C. C. Long, Roger Dickinson, Jack Kennedy, James Kolb, and H. W. Thomas as chairman, met only twice during the past year. This Committee devoted most of its work during these meetings to a continuation of the intensive work done the preceding year, and it was gratifying to see many of the recommendations previously made and approved by the House of Delegates, adopted by the University of Arkansas Medical Center and by the 1955 General Assembly.

The most controversial issue considered during the past two years has been that of private practice by members of the faculty of the School of Medicine. It was recommended that salaries be authorized at a sufficiently high level that it would be unnecessary for faculty members to rely on private practice, to supplement their income. The recent legislature authorized these salaries which the Committee feels is an important step toward solving this problem, even though for the immediate future, funds may not be available to pay these increased salaries. The fact that the General Assembly approved the recommended increases was quite encouraging.

In addition to this topic, the Committee sponsored a continuation of a survey among lay people in various parts of the state, relative to the Medical Center. The purpose of this survey was two-fold: (1) to ascertain a layman's viewpoint on the problems concerning operation of the Medical Center, and (2) to use the survey as an opportunity to acquaint lay people with their Medical Center and its operation. This survey was conducted in cooperation with the Agricultural Extension Service, and this Committee is deeply appreciative of their efforts in behalf of the Medical Center.

A General Practice Residency Program, previously recommended by this Committee, is being established at the Medical Center this year, and it is hoped that this will develop into a very important part of Medical Education in Arkansas.

Several minor individual complaints of varied nature were referred to this Committee and recommendations made concerning the individual problems were made.

The Committee wishes to publicize the Arkansas Medical Society Scholarship Fund (formerly known as the Bill Brooksher Fund) and recommends to the House of Delegates that an effort be made to increase this fund from approximately $1,200.00 to $5,000.00.

As Chairman of this Committee, I wish to personally thank the members for their unselfish and loyal service, during the past two years, and I am also very happy that it at last appears at this time that the report of this Committee will not be as controversial as it was last year.

Respectfully submitted,
H. W. Thomas, Chairman.

★ Editorial ★

THE ANNUAL MEETING

With the publishing of the program in a previous **Journal**, and with the plans of attending the meeting of the Arkansas Medical Society now practically made, we pause only to mention that the Hot Springs session of May 30-June 1st will probably set attendance records.

Always a popular meeting place and a generous host in the Garland County Medical Society, these with certain extra-curricular activities for both the physicians and their wives, have made the famous Spa most popular.

Alfred Kahn, Jr., of Little Rock and his committee, have provided a carefully diversified program for the three-day venture and our gratitude is extended to them for a piece of work which is so often unhonored and unsung. No physician can attend without coming away just a little improved in his professional ability.

We will be there.

WORK FOR OUR MEDICAL ALUMNI

One of the middle states of our country is the proud possessor of an active energetic Medical Alumni Association. This Association, within recent months, has secured private, voluntary, donations running into six figures, for its Medical School. It was done with some publicity but with more of the old-fashioned simpler way of sitting down and drawing a check to the Alumni Fund.

Arkansas Alumni of the Medical School have shown more than a passing interest in the matter. We are not authorized to tip any hands but we believe there's smoke visible in the camp of our Alumni and we hope there's fire and plenty of it.

There is a close liaison between the Alumni and the Board of Trustees of the University. We have been privileged to see some of its correspondence and believe that something can and will be done to provide endowment and/or other funds for the Medical School. These funds should come from alumni and from others who live and work in Arkansas. While some physicians might feel indebted to other schools, there are good reasons for them to share their generosity with the state Institution. Gifts should come in large amounts from the wealthy and in generous amounts from those of us less fortunate, but we believe that all should share.

We have no truck with those who would lean on the Federal Government for support of the school. That would mean more tax and more scattered funds. We've too much of that already.

If the **Journal** can fan the smoke of the Alumni Association into a bright and cheery flame, it would feel that this space had not been wasted.

PUBLIC Physician Patient Personal RELATIONS

ARKANSAS STATE MEDICAL ASSISTANTS SOCIETY

Each member of the Arkansas Medical Society has received a letter concerning the first annual Convention of the Arkansas Medical Assistants Society to be held at the Arlington Hotel, Hot Springs, May 28 and 29.

Please encourage your assistant to attend. We believe that you will profit by her attendance and membership.

The formation of this Society was an activity of the State Medical Society Public Relations committee and apparently is one of the most fruitful endeavors.

The program for the Convention will be most informative and entertaining. Remind your assistant to make reservations and plans to attend now.

And Clipping Bits Here and There

Arkansas TRAVELING

ARKANSAS MEDICAL SOCIETY
Hot Springs, May 30 - June 1

ARKANSAS ACADEMY OF GENERAL PRACTICE
Hot Springs, May 30

AMERICAN MEDICAL ASSOCIATION
Atlantic City, June 6-11

Cities are the cancer of civilization.—Thomas Jefferson.

on all 4 counts

ACH

- wide spectrum of effectiveness
- rapid diffusion
- prompt control of infection
- minimum side effects

the decision often favors

ROMYCIN*

HYDROCHLORIDE
TETRACYCLINE HCl *LEDERLE*

Compared with certain other antibiotics, ACHROMYCIN offers a broader spectrum of effectiveness, more rapid diffusion for quicker control of infection, and the distinct advantage of being well tolerated by the great majority of patients, young and old alike.

Within one year of the day it was offered to the medical profession, ACHROMYCIN had proved effective against a wide variety of infections caused by Gram-negative and Gram-positive bacteria, rickettsiae, and certain viruses and protozoa.

With each passing week, acceptance of ACHROMYCIN is still growing. ACHROMYCIN, in its many forms, has won recognition as a most effective therapeutic agent.

Lederle

LEDERLE LABORATORIES DIVISION *AMERICAN Cyanamid COMPANY* Pearl River, New York

*REG. U. S. PAT. OFF.

Obituary

J. BROOKS TATE, 45, of Texarkana, died unexpectedly in a Texarkana hospital March 18, 1955. He was a member of the Miller County Medical Society, the Arkansas Medical Society and the Southern Medical Society. He was a native of Russellville, Arkansas.

His medical degree was obtained from the University of Arkansas School of Medicine and he had practiced his profession in Texarkana for the past twelve years. He has been an outstanding leader in his community.

Survivors include his widow, a son, and a daughter, of Texarkana; his parents, Dr. and Mrs. A. B. Tate, Sr., and a brother, Dr. A. B. Tate, Jr., of Russellville.

Funeral services were conducted in the Walnut Street Church of Christ of Texarkana. Burial was in Atkins, Arkansas.

WILLIAM S. HUTTO, 79, Damascus, died March 27 at Memorial Hospital in Conway. He formerly lived in Clinton and had been in ill health for more than two years.

He began his practice of medicine in Van Buren County in 1897, when he was 19 years old. He was on the staff of Van Buren County Memorial Hospital at Clinton and a member of the Damascus Baptist Church and the Arkansas Medical Society.

Survivors include his wife, three sons, four daughters, three sisters, 16 grandchildren and four great-grandchildren.

Funeral services were held at the First Baptist Church of Damascus and burial was in Springfield Cemetery.

CHARLES GORDON LEVERETT, 44, McGehee physician and civic leader, died March 10 in the Dermott hospital.

Rites were held at the McGehee Presbyterian Church by Rev. Willian McLean, Rev. Mouzon Mann and Rev. Cline Ellis. Burial was in McGehee Cemetery by Dyer Funeral Home.

Dr. Leverett was a native of Conway and a graduate of the University of Arkansas Medical School. He first practiced in Eudora but moved to McGehee about 10 years ago and later built the Memorial Clinic there. He was a veteran of World War II, and while stationed in England, he studied at Oxford University.

The prominent physician and surgeon was president of the McGehee School Board, president of the Rotary Club there, an elder in the Presbyterian Church, a Mason and a Shriner. He was a member of the Arkansas Medical Society, American Medical Association and the American College of Surgeons.

Surviving are his wife, Mrs. Mary Leverett; two sons, James Marion and Charles Gordon Leverett, Jr., of McGehee, and his mother, Mrs. Sally Leverett, of Conway.

EMERY O. WHITE, 72, Hamburg, died in a Crossett hospital March 31. He had been in ill health for a year. He was a native of Ashley county, attended public schools here and the University of Arkansas School of Medicine, Little Rock. He received his license to practice in 1907.

He came to Hamburg in 1931 where he established a practice that reached throughout the county.

He was a member of the Ashley County and the Southeast Arkansas Medical Societies. Dr. White was a 32nd degree Mason, a Shriner and a member of the First Baptist Church, Hamburg.

He was married to the former Miss Minnie Lee Rawls in April, 1911, who survives. In addition to his wife, Dr. White is survived by three daughters and three grandchildren.

Funeral services were held at the First Baptist Church.

W. H. TOLAND, 87, Nashville physician and former legislator and state officer, died April 11 in a Little Rock hospital.

Dr. Toland fell and broke his leg while in Little Rock on business about two weeks ago. He was recovering when he suffered a stroke Thursday.

He had served as chairman of the Arkansas Medical Examining Board and was Howard county representative in the legislature, 1931-49.

Born in Bingen, he began his practice in Mineral Wells after graduating from Vanderbilt Medical School. He moved here in 1912, acquiring large farm interests. He was a member of the Arkansas Medical Society and was a Mason and Shriner.

Survivors include a son, a daughter, Nashville; six grandchildren and 10 great grandchildren.

Funeral services were conducted in Mineral Springs Cemetery.

THE DOCTOR, A CITIZEN

The letters "M.D." after our names do not exempt us from the citizen's responsibilities. On the contrary, a glance at 2,500 years of medical history will show that when the doctor is responsible to the whole community, he is most responsible to his primary obligation, the health and healing of his patient.

Only when we see our obligation to the patient as part of a prior responsibility to our fellow men can we maintain the integrity of Medical Ethics. Responsibility to community and responsibility to patient are not separate, conflicting claims, but parts of a whole, and neither obligation can be discharged apart from the other.

A profession that furnished six of the fifty-nine signers of the Declaration of Independence cannot afford to neglect political responsibility when the very essence of democratic government is threatened at home and abroad. We ought not to let the "M.D." after our names disenfranchise us as voters and active participants in political organizations—A. M. Phillips, M.D., in Southern Medical Journal.

ALL DOCTORS SHOULD KNOW

Apparently it is not generally realized that the only voice the practicing profession has at the international level is the World Medical Association. An increasing number of problems pertaining to medicine and its methods of practice are being discussed at that level. With the exception of the World Medical Association, all these organizations are either governmental or semi-governmental. While governments have an interest in medicine their viewpoint should not be the only vocal one.

What are these problems of vital concern to the individual doctor?

1. Certain national and international groups are attempting to establish a code of international medical law governing the activities of doctors in both peace and war, wholly ignoring the rights and privileges of the doctors themselves.
2. The International Social Security Association has adopted resolutions which when implemented will force its philosophy on the medical profession. To date it has refused even to discuss medical problems of social security with representatives of WMA.
3. Various governmental and semi-governmental bodies are ignoring the principles of medical secrecy.
4. One international organization had adopted a resolution controlling the doctor's treatment of his patient.
5. This same organization has a plan to revise medical education according to its philosophy.

How many doctors are even aware of the existence of these problems, much less of the actions of the World Medical Association to combat them? Far too few. All doctors should be enlightened.—**World Medical Journal, January, 1955.**

(From the AMA)

ADDITION TO AMA FILM LIBRARY

"The Valiant Heart" is the title of a new film which has been added recently to the library of AMA's Committee on Medical Motion Pictures. This 27-minute black and white sound film tells the story of an eight-year-old boy suffering from rheumatic fever. The manner in which the doctor, public health nurse, teacher and neighbors rally to help the boy and his family is a dramatic demonstration of the fact that rheumatic fever is a bigger problem than any one person or family can handle.

FOR SALE

Memorial Clinic, located at 204 North Fourth Street, McGehee, Arkansas, fully equipped with laboratory, X-ray room, X-ray developing room, two doctor's offices, doctor's lounge, one hospital room, physiotherapy room, E.N.T. examining room, five examining rooms for white patients, two examining rooms for colored patients, reception room for white patients, reception room for colored patients, chart room, emergency room, and business office. This clinic has been in operation since January, 1950.

Please write: Mrs. Mary T. Leverett, McGehee, Ark.

INDEX

THE JOURNAL OF THE ARKANSAS MEDICAL SOCIETY

VOLUME LI

June, 1954 — May, 1955

ABBREVIATIONS—

(O) Original Article; (SP) Special Article; (E) Editorial; (OB) Obituary; (R) Resolution.

— A —

Address, An, (O) 196
Address, President's (SP) 1
Address, President's Inaugural (SP) 4
Adrenalectomy, What is Being Accomplished by (O) 106
AMA Meeting, The San Francisco, Report of (SP) 72
Anaesthesia in General Practice (O) 25
Arnold, W. O. (O) 65
Auxiliary News (SP) 38; 60; 154; 194; 219

— B —

Bailey, H. A. Ted (O) 205
Baker, J. J. (OB) 198
Barnett, James R. (OB) 98
Beaty, S. S. (OB) 124
Biliary Diseases, The Surgical Aspects of (O) 222
Biscoe, Goree (OB) 214
Bleeding, Late Post-Partum (O) 70
Bogart, H. D. (OB) 188
Book Reviews, 60; 104; 172; 194; 220
Bremer, Joseph P. (OB) 75
Brooksher, W. R. (SP) 4

— C —

Capel, C. B. (OB) 75
Casada, B. F. (OB) 55
Cerebral Circulation, Concerning (E) 272
Cholecystectomy, The Complications of; Prevention and Treatment (O) 29
Committee on Cancer Control (SP) 24; 61; 85; 105; 132; 155; 173; 195; 221; 261
Committee Reports, Annual, (SP) 231
Committees, Arkansas Medical Society, for 1954-55 (SP) 81; 145
Cortisone, The Use of, During Pregnancy (O) 180
County Medical Society Officers for 1954 (SP) 82
Cox, A. E. (OB) 124

— D —

DeCosta, Edwin J. (O) 180
Dickinson, R. C. (SP) 1
Dickinson, Rodger (O) 113
Dillaha, Calvin J. (O) 266
Diseases of Civilization (E) 96
Douglass, S. W., Sr., (OB) 124
Douglass, Thomas C. (O) 29; (OB)
Duncan, Fred (OB) 55

— E —

Ellis, C. Randolph (O) 50
Ellison, Eugene T. (O) 71

— F —

Felts, James E. (OB) 98
French, W. Edward (O) 222

— G —

General Practice in Rural Mexico (O) 47
General Practice, The Challenge of (O) 50

— H —

Hancock, W. G. (OB) 188
Harrell, Wm. B. (O) 262
Hathcock, A. H. (O) 211
Headstream, James W. (O) 106
Hemorrhagic Disease of the Newborn, Factors Predisposing To (O) 132
Hildebrand, W. B. (O) 196
Hoge, Arthur F. (O) 86
Hoge, Marlin B. (O) 86
Hoge, Solomon F. (OB) 214
Hollingsworth, G. F. (OB) 99
Horn, Wm. H. (OB) 145
Hunt, Earle H. (OB) 165 (R) 186

— I —

Integration of the Patient (E) 185
Intestine, Differential Diagnosis of Organic and Functional Disorders of the (O) 39

— J —

Jackson, Robert R. (O) 176
Jones, W. E. (OB) 75

— K —

Kahn, Alfred (E) 96; (E) 185; (E) 272
King, O. S. (OB) 17

— L —

Lawson, Wilbur G. (O) 132
Leadership, On (E) 166
Lesh, Ruth Ellis (O) 174
Lewis, James F. (O) 115
Lung Disease, Cystic, And Other Ventilatory Problems (O) 65

— M —

Maternity Program For Indigents, Texarkana's (O) 262
Medical Assistants Association (SP) 92; 167
Medical Ethics (O) 113
Munger, Horace V. (O) 157

— MC —

McCurry, D. K. (OB) 55
McKnight, J. F. (OB) 92

— N —

Nasal Septum, Physiological Surgery of the, and Associated Structures (O) 62
Norwood, M. L. (OB) 165

— O —

Obstetric Trends in a Small Hospital (O) 225
Obstruction, Intestinal (O) 90
Ophthalmology, Industrial Problems in (O) 161
Outlook for Man, The (O) 163
Overstreet, W. C. (OB) 189

— P —

Parsons, Earl (O) 134
Phelps, Malcolm E. (O) 25
Poliomyelitis Patient, The Management of the Acute Severely Involved (O) 176
Proceedings of 78th Annual Session of the Arkansas Medical Society (SP) 5
Psychiatry and Religion (O) 135
Public Relations Column (SP) 33; 74; 95; 148
Pulmonary Embolism (O) 115

— R —

Rectal Injury (O) 210
Retrolental Fibroplasis in Arkansas, Preventive Program For (O) 140
Rhinehart, D. A. (R) 151; (R) 98; (OB) 55
Rhinitis, Vasomotor, Satisfactory Management of (O) 205
Ringworm of the Scalp, What is the Best Way to Treat (O) 226
Riggs, Ralph H. (O) 62
Robins, R. B. (O) 163; (O) 226
Ross, James Harvey (O) 47
Rural Practice, Why I Entered (O) 92

— S —

Saltzman, Ben N. (O) 92
Setting Fees in Insurance Cases (O) 110
Simmons, Calvin R. (O) 225
Souter, Thomas (OB) 125
Southall, S. A. (OB) 165
Sparks From the Secretary (SP) 32; 57
Stell, J. S. (OB) 98
Stinnet, Mr. C. L. (O) 110
Storm, George R. (OB) 32

— T —

Thornton, Wm. D. (O) 70
Tuberculosis Abstracts (SP) 34· 53; 99; 125; 149; 169; 187; 216; 274
Tumors, Pelvic, With Ascites and Hydrothorax (O) 174

— U —

Ulcer, Primary Gastric Resection in the Treatment of Perforated Gastroduodenal (O)
Urological Problems, Pediatric, Advances in Care of Common (O) 156

— V —

Van Beber, J. A. (OB) 189
Veterans' Medical Care—An Issue For Citizens (O) 226

— W —

Wakefield, E. G. (O) 39
Walker, John K. (O) 225
Webb, Floyd (OB) 55
Wortham, James T. (O) 106
Worthington, G. M. (OB) 106

TUBERCULOSIS ABSTRACTS

A Review for Physicians

ISSUED MONTHLY BY THE NATIONAL TUBERCULOSIS ASSOCIATION

PERIODIC EXAMINATIONS

By H. CORWIN HINSHAW, M.D.

Bulletin, National Tuberculosis Association, January, 1955

The purpose of periodic examinations of persons in apparent good health is identical with that of other medical examinations: to detect disease in its earliest phases of development and to counsel persons in matters of health preservation.

Who should be examined? The more important a person is to society, to relatives and dependents or to business associates, the more important his health becomes. Key men in business, mothers of children, heads of families and those with other important missions to perform must conserve their productive capacity. Disability from preventable illness constitutes a serious threat to successful attainment of goals in life.

Many corporations regard the health of their executives as valuable assets to be conserved. Often they require executives to undergo periodic examinations at intervals of from six to twelve months, the expense being borne by the corporation. Labor unions look to the welfare of their members but few have come to recognize the need for examinations of the type advocated here. Physicians, who bear grave responsibilities to many people, are notably negligent of their own health, often because they fear to impose upon busy colleagues.

Persons with a history of chronic or recurring ailments, notably diabetes, tuberculosis, hypertension, duodenal ulcer, and other conditions have learned by experience that medical care is part of personal maintenance.

Examination Techniques

Many physicians have learned that the examination of persons who believe themselves to be well is no simple task. The skill and judgment required is at least equal to that needed for the care of the sick. The procedure of conducting an examination should be familiar to that ordinarily employed when the subject is known to be ill.

A thorough medical history, interpreted by a physician with a broad knowledge of internal medicine, may yield clues to health hazards not previously recognized. A careful record of past ailments is secured, with emphasis upon conditions which tend to persist or recur. Often the past medical history must be supplemented later with clinical and laboratory records, X-ray films and the findings and opinions of previous physicians. The patient's recollections and his current opinions concerning previous illness may be faulty.

If the patient has noted any abnormality of function or volunteers any symptom, or if he expresses any special fear of disease, these are recorded in detail. Finally, specific questions are asked with respect to each organ system. The end result is a complete and orderly inventory of the functional status of all parts of the body insofar as these have appeared to the patient.

The physician should probe into the emotional problems and occupational strains which may relate to health and happiness. It is important to record habits of eating, sleeping, and recreation, as well as the nature and intensity of physical and mental effort expended in occupational pursuits. The consumption of alcohol, tobacco, sedatives, and self-prescribed medications should be estimated in quantitative terms. Often it is wise to inquire directly concerning sexual habits and marital problems. Many persons who would never open such topics of conversation are eager to share their problems with an understanding physician and are benefited by doing so.

The physician should know his patient's ambitions, accomplishments, and plans for the future as well as his frustrations and failures. The physician, like the minister and the lawyer, is often in a position to assist the patient in analyzing his life program.

Physical examination of the apparently well person must be fully as meticulous and complete as in the case of the ailing person. Minor deviations from normality are evaluated as possible incipient disease. All accessible structures are observed closely and examined with seeing hands. The actions of the heart and lungs are determined by traditional methods of physical exam-

ination. If blood pressure is elevated it is determined repeatedly until a base level is recorded. The body orifices, including the ocular fundus, the nasal and oral cavities, the rectum and vagina are examined visually and probed with examining fingers or instruments.

Laboratory and X-ray studies will be planned after the medical history and physical examination have been completed. Each test will be chosen to answer a specific question, often a question which arose as a result of the interview or examination. In addition to the special tests certain routine examinations are necessary. An X-ray examination of the lungs and heart is essential to all cases. Blood counts and urine analysis also may reveal conditions not producing symptoms or findings. Very few cases are found by the routine serologic test for syphilitic infection but it has become traditional. Electrocardiograms are indicated if the patient is over the age of forty-five years. Even a normal tracing may become valuable for purposes of comparison if cardiac disease appears later.

The success of some community-wide antituberculosis X-ray screening programs has suggested that tests to detect other diseases should be devised and applied to large population groups. Many physicians and public health experts are opposed to such multiphasic screening programs except as research projects. The reasons for such opposition are obvious if comparisons are made between the requirements of a thorough examination and those of a series of simple laboratory tests. An easy and inexpensive way to make everybody healthy has not been found.

The National Tuberculosis Association and its affiliated health organizations can do much to popularize good and thorough periodic medical examinations. The problem is largely one of health education and medical economics. People have already learned that periodic dental examinations are wise and economical. Parents have already learned to consult pediatricians for advice and care of well children. When private pediatricians cannot be had, well baby clinics are provided. Why not well papa and well mamma clinics?

The actual cost of periodic health examinations by private physicians is not beyond the reach of the average working man. Maintenance of a man costs less than maintenance of an automobile. The cost of trading the serviceable old car for a new model is greater than the cost of a major illness. The cost of maintaining a good sickness insurance policy is less than the cost of smoking a package of cigarettes daily. Women spend more in beauty parlors than in doctors' offices. Many families who spend hundreds of dollars annually on luxuries and vices are considered to be "medically indigent." Values and standards are distorted through ignorance and improvidence.

Readers of popular magazines learn much about modern medicine, much that is true and some that is half true. Our elementary and secondary schools should now have organized courses in medical science, teaching anatomy, physiology and pathology. Such knowledge in the next generation would lead to better appreciation of health and good medical care. Money now spent on nostrums and quacks would be devoted to the purchase of adequate preventive and curative medical care.

The voluntary health organizations are the most potent factors in health education in America today. Their support should be directed toward securing the best medical care for well people as well as for persons who are ill.

Proceedings of Societies

New Booklet on Federal Income Tax Liability

The A.M.A. Law Department has compiled a booklet on the federal income tax liability of physicians, consisting of a reprinting of four articles which appeared recently in **The Journal.** This booklet is available to state and county medical societies and individual physicians, without charge, by writing the Law Department, American Medical Association.

C. N. Jones was named president of the Sevier County Medical Society as that group held its annual election of officers March 28.

Vice president of the group will be Rodger Dickinson; W. G. Pullen will be secretary-treasurer; C. N. Jones will be delegate to the State Medical Society convention.

Washington County Medical Society recently placed "Today's Health" on the reading tables

of every high school library in the county. At the April meeting it voted to give an outstanding senior member of the Pre-Med Club of the University of Arkansas a "Gray's Anatomy" on Honor's Day at the University.

The Craighead-Poinsett County Medical Society, meeting April 13th, was attended by a large percentage of the membership who heard a humorous illustrated lecture on pelvic pain by Willis Brown of Little Rock. President-Elect L. H. McDaniel also spoke to the group.

The Society voted unanimously to contribute to the Brooksher Scholarship Fund to assist some worthy student through the University of Arkansas School of Medicine.

J. H. McCurry, Secretary.

The Ouachita County Medical Society met in regular monthly dinner session Thursday evening, April 7, at Camden.

The program consisted of a very interesting combination movie-talk entitled "A Surgical Tour Around the World" by Harry Hayes of Little Rock. R. B. Robins, Secretary.

Personal and News Items

The State Headquarters Office advises that an increasing number of inquiries are being received from physicians in the various specialties who are seeking a connection with a clinic or an association with a group of doctors. If the need for a specialist develops in your group, let Mr. Schaefer know.

Contributors to the American Medical Education Foundation from the State of Arkansas during Month of February and March, 1955:

W. R. Brooksher, Fort Smith.

Polk County Medical Society.

J. Harry Hayes, Little Rock, addressed the Woman's City Club in Little Rock on his recent world tour.

W. Paul Dickson and John Henry Kilgore announce the opening of Dickson and Kilgore Clinic and Hospital in Caraway.

The clinic-hospital, located in the former Poff Clinic, will be for the practice of general medicine and surgery.

John Mc. Smith, Little Rock, Euclid M. Smith, Hot Springs, and Mrs. Mason Lawson, Little Rock, are Arkansas names appearing on the program of the Medical Assistants meeting in Hot Springs May 28-29. Out-of-state speakers are A. R. Sugg, Ada, Okla., and Henry Gatten, Memphis.

John Hamilton, pathologist at the University of Toronto, addressed the Pulaski County Medical Society April 4 at the University of Arkansas School of Medicine.

Doctor's Day was sponsored in many communities in the state by the Woman's Auxiliary societies. March 30 is the accepted date for the occasion because this day is the anniversary of the first use of ether for anesthesia, accomplished by Dr. Crawford Long of Georgia.

William Parker has returned to his home in DeValls Bluff and reopened his offices early in March.

Governor Faubus announced the designation of Joe Verser, Harrisburg, as secretary of the State Medical Board last month. The **Journal** congratulates Dr. Verser both in his present appointment and on his past performance in that office.

T. S. Van Duyn, Stuttgart, and his family were honored by a special article in the Arkansas Democrat on the occasion of the opening of his new clinic in Stuttgart.

Nearly 1,000 nurses and persons in the ancillary services attended the Arkansas League for Nursing meeting in Little Rock the last of March.

M. O. Peeler, Jonesboro, is building a new 19-room clinic and expects to be settled in the new structure with Durwood Wisdom and with W. F. Shepherd who joins them in about three months.

At the January meeting of the Arkansas State Board of Health, D. W. Goldstein of Fort Smith was elected president, and E. D. McKnight of Brinkley was elected vice-president. Goldstein succeeds Don Hamm of Clarksville as president.

WOMAN'S AUXILIARY

In January the Clark County Auxiliary gave a Nurse Recruitment Tea for the senior girls of Arkadelphia High School. The film "Girls in White" was shown and they were told about the loan funds and opportunities in the nursing field.

In March, new officers were elected as follows: President, Mrs. Albert Thompson, Gurdon; Vice President, Mrs. Lewis Tilley, Arkadelphia; Secretary, Mrs. T. T. Ross, Gurdon; Treasurer, Mrs. Robert Sawyer, Arkadelphia.

On March 29th, a dinner was given at Mrs. Jack Kennedy's home by the Clark County Medical Auxiliary for their husbands in honor of Doctor's Day.

The Pulaski County Medical Auxiliary gave fifty dollars to the American Medical Education Foundation Fund as a tribute to their doctors on Doctor's Day. They are having a dinner party and evening of entertainment for the doctors and their wives on Wednesday, March the 30th.

Mrs. Mason Lawson of Little Rock will be installed as President of the Woman's Auxiliary to the American Medical Association at their thirty-second annual convention to be held in Atlantic City, New Jersey, June 6th to 10th. Headquarters for the convention will be at the Hotel Haddon Hall.

The Woman's Auxiliary to the Boone County Medical Society entertained Mrs. Hoyt Choate, President of the Woman's Auxiliary to the Arkansas Medical Society, and Mrs. L. Gardner, past president of the Woman's Auxiliary to the Pope County Medical Society and Chairman of the State Program Committee, at a luncheon at Spring Lake, near Harrison, on March 16th. The motif of the luncheon table decorations was in honor of St. Patrick's Day.

Following the luncheon there was an afternoon session held at the home of Mrs. Ross Fowler. Mrs. A. R. Hammon, President of the Boone County Medical Society Auxiliary, presided, and Mrs. Choate gave a very interesting and informative talk outlining the various activities of the Arkansas State Auxiliary.

Out-of-town guests were Mrs. Herbert Klemme, of Yellville, and Mrs. David M. Russell, of Jasper.

Mrs. G. Allen Robinson, Secretary.

Mrs. W. J. Wright was hostess March 4 to the Woman's Auxiliary of the Crittenden County Medical Society. Mrs. T. S. Hare, Crawfordsville, reported on the projects sponsored by the AMA namely, Civil Defense, Health and Safety campaigns in the community, etc. There was some discussion of the Student Loan Fund.

Mrs. Wright reported ten subscriptions to "Today's Health." Doctor's Day will be observed on March 30th.

Mrs. J. T. Irby presented an informative program based on the Auxiliary's Creed. Mrs. H. S. Watson and Mrs. J. H. Matthews gave highlights on "Miracle Drugs—Your Life and Vegetables."

Mrs. Milton Lubin of Turrell was welcomed as a new member.

The Annual State Convention will be held in Hot Springs, May 30-31-June 1st.

Mrs. J. H. Matthews, Reporting.

The Woman's Auxiliary to the Pulaski County Medical Society entertained with a dinner at the Little Rock Country Club in honor of Doctor's Day, Wednesday, March 30th. A social hour from seven to eight o'clock preceded the dinner. The tables were decorated with white candles and bouquets of red carnations and candytuft. The arrangements were made by Mrs. John Hundley, Mrs. Harry Hayes, Mrs. James Headstream and Mrs. Harvey Shipp. One hundred and sixty guests attended the dinner.

Mrs. James Newbill,
Publicity Secretary.

At the March meeting of the Woman's Auxiliary to the Jefferson County Medical Society, new officers were announced by Mrs. Clyde Hart, Jr., nominating committee chairman as follows: Mrs. W. T. Lowe, president; Mrs. W. J. Wilkins, Jr., president-elect; Mrs. Arthur Fowler, Jr., vice-president; Mrs. Ralph Wooley, secretary; Mrs. T. E. Townsend, treasurer; Mrs. O. C. Raney, publicity secretary; Mrs. W. H. Bruce, historian; and Mrs. Ross Maynard, parliamentarian. This meeting was held at the Davis Hospital with Mr. R. C. Warren, hospital administrator, welcoming the group. Guest speaker was Mrs. Dorothy Myers, assistant to the Dean for Social Service of the University of Arkansas Medical School. She reported the results of a recent survey in Arkansas concerning the State Medical Center and its services. Problems of the Center and possible solutions were discussed. It was pointed out that the Center could mean a great deal to the community in help with unusual medical cases. Also medical experimental work in

Perry County, financed by Winthrop Rockefeller, was described also by the speaker.

Doctor's Day—Jefferson County Medical Auxiliary

Doctor's Day was observed in a meaningful way when members of the Woman's Auxiliary to the Jefferson County Medical Society presented R. C. Warren, Davis Hospital administrator, with a check for $950.33 the proceeds from the Auxiliary's recent style show tea. The doctors all wore red carnations given them by the Auxiliary, and a dinner was given in their honor at the Pine Bluff Country Club. Mrs. Arthur Fowler, Jr., chairman of Doctor's Day, stated that the purpose of the day was to honor members of the medical profession both living and dead.

Mrs. E. L. Hutchinson,
Publicity Chairman of
Jefferson County Auxiliary.

BOOK REVIEWS

Peripheral Vascular Diseases: Edgar V. Allen, M.D., Professor of Medicine, Mayo Foundation, Graduate School, University of Minnesota; Nelson W. Barker, M.D., Professor of Medicine, Mayo Foundation, Graduate School, University of Minnesota; and Edgar A. Hines, Jr., M.D., Professor of Medicine, Mayo Foundation, Graduate School, University of Minnesota. Second Edition, Cloth, $13.00. Pp. 826. 316 Illustrations. W. B. Saunders Company, Philadelphia, 1955.

This unusual reference and textbook should be equally as important to the practitioner as to the student. There are twenty-seven chapters, the first three of which are most useful in that they are used to familiarize one with definition of terms; to give a satisfactory approach to the diagnosis of vascular diseases of the extremities; and outline special methods of investigation which, in this reviewer's opinion, will be most helpful if performed by a team which does such investigations regularly and frequently. The next twenty-two chapters comprise a very comprehensive study of the many disease processes of the vascular system, including those due to environmental temperature, aneurysms, scalenus anticus syndrome, tumors of the blood and lymph vessels and purpura. The last two chapters deal with medical and surgical treatment of these various disorders. Many of these will be especially useful to general practitioners.

This reviewer recommends PERIPHERAL VASCULAR DISEASES to all who are interested in the diagnosis and management of these conditions.—G. H. Butler.

Healthier Living: Justus J. Schifferes, Ph.D., Director, Health Education Council and Instructor in Health Education, Teachers College, Columbia University. Pp. 928. Illustrated. John Wiley & Sons, Inc., New York.

This volume, written by a layman whose experience in the publication of medical subjects goes back ten years, presents in every day language the problems of achieving healthier living, especially as they relate to the college student and the student's particular environment—the college campus. Admirably suited as a textbook for a college course in personal and community health, it seems to this reviewer that the author has, nevertheless, over simplified the technical aspects of the physiological and psychological basis of the study of hygiene. Particularly helpful are the chapters on the social aspects of sexual adjustment before and after marriage, the contrast between the relationships of normal emotional development to mental health and the various types of failure in life adjustment and their attendant mental illnesses, and finally some sound practical advice on how to obtain good medical attention and suggestions on how to avoid quacks, cults and fads. The section on Community Health covers the subjects of microbiology and epidemiology, the control of respiratory and venereal diseases, and concludes with a discussion of the problems associated with the maintenance of health on a national and international scale. Each chapter of the book ends with a lucid summary, a bibliography which gives the reader an idea of the content and value of each of the references and an excellent list of questions for class discussion and review.

The volume is well illustrated with anatomical sketches by Louise Bush, Ph. D., which help clarify the text, especially in the chapters on the physiology and hygiene of the various organs and systems of the body.

The author draws rewardingly upon his years of teaching experience at Columbia University which makes of this book a highly readable and valuable textbook for the teacher and student of college hygiene.—J. Hervey Ross.

Ion Exchange and Adsorption Agents in Medicine: Gustav J. Martin, Sc.D., Research Director, National Drug Co. Pp. 333. Illustrated. Little Brown & Co., Boston. $7.50.

In spite of its forbidding title, this absorbing little book gives the impression that the reader is getting a preview of the future.

Assuming that the exchange ion resin might be valuable in the treatment of peptic ulcer the author proceeds in his study of other conditions, chiefly Sodium Retention, that give promise of good results with resin therapy. The resins, he explains, are used by mouth and are kept as a constant habitat of the bowel, which is their "locus operandi."

The author further visualizes that after more information on the resins is available, that they may be used to prevent some of the chronic toxic condition whose cause is not now known. One is reminded of the volumes on "autointoxication" which flowed through our literature a generation ago. This reviewer ventures to suggest that if some resin exchange ion agent can be found which by its simple action can help control eclampsia, that this alone would make the work worth while.

UNIVERSITY OF CALIFORNIA
Medical Center Library

THIS BOOK IS DUE ON THE LAST DATE STAMPED BELOW

Books not returned on time are subject to fines according to the Library Lending Code.

Books not in demand may be renewed if application is made before expiration of loan period.

7 DAY
RETURNED
MAR 30 1959

10m-12,'54(9093s4)4128

5T

99635